MENTAL HYGIENE

VOL. [illegible] APRIL, 1947 NO. 2

CONTENTS

THE [illegible] COMMITTEE FOR MENTAL HYGIENE, INC.
[illegible] BROADWAY, NEW YORK, N. Y.
[illegible] New York, N. Y.
[illegible] Foreign, $1.25 Single copy, $1.25
[illegible] Second Class Matter at the Post Office
[illegible] Act of March 3, 1879, under the act of August 24, 1912
[illegible] September 1927, and of October 2, 1918.

MENTAL HYGIENE

VOL. XXXI APRIL, 1947 No. 2

THE NEW PUBLIC PSYCHIATRY *

GEORGE H. PRESTON, M.D.

Commissioner of Mental Hygiene, State of Maryland

PUBLIC psychiatry faces a crisis. Unless we meet this crisis and solve it, non-medical persons, with little knowledge of psychiatry, will take over. This is no new crisis. It has been developing for years. War-time disorganization served to intensify it. Lack of money has been a major factor in it. Our hospitals need more money, and some hospital administrators believe that money alone will solve the problem. This is not true.

The real problem lies in a change that has taken place in psychiatry. In addition to the treatment of patients in hospitals, psychiatry to-day includes the treatment of habit disorders in well babies, of emotional disturbances and behavior disorders in children, of marital disorders, of impotence and frigidity, of gastric ulcers, of hypertension, of cardiac neuroses, of obsessional states, of phobias, of the whole realm of social maladjustments. Present-day psychiatry touches obstetrics, gynecology, pediatrics, cardiology, surgery, internal medicine, and even dermatology. No psychiatrist in the future will be considered competent for general psychiatric practice unless he is able to treat such patients.

The younger men, particularly those who have seen some of the better recent psychiatry, know this. They know that, if they can treat such patients, they can carry on successful practice and they are going, for training, where they can learn that type of psychiatry. Unless state hospitals provide it, they will not attract young men. Unless they attract

* Presented at the Thirty-seventh Annual Meeting of The National Committee for Mental Hygiene, New York City, October 31, 1946.

young men for training, they will not be able to hold replacements for permanent resident positions. Unless they hold good, young replacements, the hospitals are doomed.

What is true of physicians is in large measure true of psychiatric nurses and psychiatric social workers. Like any other competent workmen, they want to work with the best, most favorable, and most rewarding material. Such material does not come to state hospitals. It exists in the community among those patients who come to the therapist saying, "Please show me how to help myself out of my illness," among those patients who want treatment and who are able to coöperate.

Professional groups can be interested in hospital work, and can be made enthusiastic about it, but only if public psychiatry changes its point of view. That change does not suggest any decreasing need for hospitals. Public psychiatry needs and will continue to need better hospitals, better supported, better equipped, better and more fully staffed with a wider range of professional people.

The necessary change in point of view relates to the changes that have already taken place in psychiatry. Twenty-five years ago there were in my community three psychiatrists who did not have direct, personal association with an institution. If you said "psychiatrist" to a patient, he did not know what you meant. If you mentioned the physician in question, the patient said, at once, "That means such and such a sanitarium, doesn't it?" The patient was not sure of the physician's name, but knew the institution. To-day, in the same community, there are thirty psychiatrists, most of them without personal institutional connections.

During the same period the number of patients in psychiatric hospitals has increased. This simply emphasizes the point. We need hospitals, better hospitals and more of them, but psychiatry has grown so that it is now concerned with many non-hospital patients. In contrast, public psychiatry has to a large measure continued to develop as if the words "psychiatry" and "hospital care" were equivalent. That point of view must be changed.

Public psychiatry needs better hospitals, better supported and better staffed. Every hospital administrator has been

repeating that statement, for the most part futilely, for years. He has been saying it futilely because he has been talking about something that most citizens felt to be separate from their daily lives, apart, walled off, and in a large measure hopeless.

Recently—and fortunately—vivid publicity in regard to hospitals has aroused the active interest of small groups of citizens. These groups of interested citizens can save the situation, but only if they bear certain fundamental facts in mind.

The first fact is: No tax-supported agency can deliver better service than that demanded by an informed, organized, and vocal group of citizens. This is true of water supplies, of sewage systems, of fire protection, of roads and schools. It is equally true of psychiatric hospitals.

The second fact that groups of citizens must remember is: No building ever cured a patient. Patients can be cured only by trained people. They can be cured at home or in tents or barns or crowded wards, if there are enough trained people to spend enough time with each patient. Unfortunately, the best-trained people are often the most inconspicuous and the least vocal. Dirt makes a noise in hospitals; so does overcrowding; so does poor food; so do patients without clothes. Lay investigators rarely know whether an attendant, a nurse, a social worker, or a physician is competent psychiatrically. They must learn how to find out if they are to help.

It is easy for a group of citizens to be vocal. It is somewhat more difficult to be well organized. It is very much more difficult to be well informed about a subject as complicated as public psychiatry. Lay groups that focus their attention solely on bigger and better hospitals will eventually destroy those hospitals. They will destroy the hospitals because state hospitals, no matter how fine they become, can no longer stand alone, separated from the community, isolated and interested only in the patients on wards. Hospitals cannot do that because, if they do, they cannot keep trained people, and without trained people any hospital is doomed.

If and when such informed groups of citizens are formed,

they will force a change of attitude on the part of some hospital administrators.

Superintendents must show such groups what is wrong with the hospitals. They must show the public what is done poorly and what is not done. They must do more than that. Hospitals must be shown going somewhere, aiming at something, following some well-worked-out plan. The need for a plan is imperative. No hospital can face the public demand that is developing to-day without plans. With sound plans, sold to an organized, vocal, and informed citizens group, hospitals can reach their goal—the goal of curing patients and returning them to the community. In the process of doing their job well, they will also train people to carry on the job.

There are thus two elements on which the future of public psychiatry rests. One element is an organized, vocal, and informed group of citizens; the other is well-formulated plans.

The common factor in the information that lay groups need and in the plans that superintendents must present has already been stated. Trained people and only trained people, working in sufficient numbers, under reasonable conditions, and for reasonable hours, can ever cure patients. The problem is how to attract and hold trained people. Salary alone is not enough. Salary plus good living conditions, reasonable hours of work, recreation, and easy transportation to centers of population will help. Good personnel work, including careful introduction to the job, practical job training, and supervision that makes each individual feel worth while, will hold many employees. None of this will attract and hold top-grade professional psychiatric personnel.

To attract and hold top-grade psychiatric personnel, hospitals must provide opportunity for contact with the entire range of psychiatric problems, both those that require hospital treatment and those that do not. Hospitals must cease to function as the center, the heart, the all-important element in public psychiatry. Public psychiatry must begin in the community, must pass through hospitals, and return again to the community. The professional staff must be given the opportunity to work all along this line, seeing and treating patients at every step.

This does not mean simply an occasional clinic. It means fundamental, continuous, personal responsibility for the life histories of psychiatric patients. To be sure, hospitals have operated clinics and out-patient departments. State systems have operated traveling clinics for children, for adults, and for paroled hospital patients. A few permanent community clinics have been established. In spite of all of this, public psychiatry has been institutional psychiatry with a few community trimmings. This point of view must change.

By way of contrast note what goes on in other fields of medicine. Most medicine begins with contact between a patient and a physician. It may go on from there to a consultation with a specialist. If hospital treatment becomes necessary, that is only an incident in the patient's medical life. The family physician or specialist who sent the patient to the hospital keeps contact with the patient during hospitalization and picks up his case again after hospitalization is over. Present plans for the control of tuberculosis should be given careful study by all psychiatric administrators, because tuberculosis, like psychiatric illness, is a life-time disease. Public psychiatry should be practiced in the same way.

Some of you will say, at once, that this is not possible because psychiatric patients stay too long in hospitals and return to the community too rarely. If you believe that, your psychiatry is still hospital focused. Let me try to unfocus your ideas.

Begin with first admissions. Almost half of all first admissions return to the community within four months and over half within one year. Maryland figures show 53 per cent. For the country as a whole, about 128,000 first admissions and 114,000 discharges [1] pass into and out of public mental hospitals each year. For over 100,000 of these patients hospital residence is an episode not unlike the prolonged general-hospital experience that might follow a severe automobile accident, or an attack of acute rheumatic fever. These hospitalized patients are entitled to the best and most skillful care the state can provide, but the very best hospitals can never reach the beginnings of psychiatric illness.

[1] Census Bureau, Series M.P. No. 9, Aug. 7, 1946

Nearly every patient who enters a state hospital has had a long psychiatric history before entrance and will continue to need psychiatric care after he comes out. One year in a state hospital may be the result of many years of psychiatric neglect before admission. Except for this neglect, no admissions might have been necessary. Think now of the patients who never come to hospitals, but who suffer throughout their lives from conditions that could have been relieved by proper treatment. These patients deserve consideration by public psychiatry. They may deserve more attention by the state than some hospitalized patients. As long as public psychiatry continues to be hospital-focused, the care of such patients will be a side line.

I am asking you to consider a public psychiatry that would be patient-focused rather than hospital-focused. Such service would begin in the community. It might start with well-baby clinics. It would certainly go on into schools and colleges. It would touch churches. It would be part of all welfare work. It should influence every phase of medical practice from the medical school to the operating room. In such a program there would be house visits to patients and their families, there would be office visits and clinic care. The program would not be a diagnostic, label-hanging affair, but an active therapeutic undertaking using all present-day techniques.

In such a service there would, of course, be hospitals, the very best hospitals, but these hospitals would be a part of the program, an essential part, but only a part, holding their proper perspective. As we indicated before, two factors are necessary to bring about such a program. The first is an organized, vocal, and informed group of citizens. This group must know what good hospitals are and they must know the value of trained people, but they must also recognize that the best hospitals in the world cannot solve the problem of public psychiatry.

The second essential rests on a change in the point of view of hospital administrators and on some change in the basic organization of hospitals. Hospital administrators must be willing to take groups of citizens into their confidence, must be willing to show them what is going on, must teach them

what really good hospitals might be, and must help to plan for psychiatric service that begins in the community, passes through hospitals, and returns again to the community.

State hospitals must be somewhat reorganized to meet such a program. I want to suggest tentatively two possible ways in which this might be done. The purpose would be to provide continuous psychiatric service in the community, from the community to the hospitals, and from the hospitals back to the community again. Suppose that in a well-staffed hospital there could be a Dr. Doe who was given responsibility, not for Ward B, but for all the patients from County X or District 3. Suppose he spent part of his time in the hospital and part in his county. Suppose he knew every physician in his county and encouraged these physicians to follow their patients through the hospital. Suppose he helped to organize clinics with local support. Suppose he had an office where he would be available for consultation. Suppose he treated or arranged for the treatment of psychiatric conditions in his county and also knew every patient and the family of every patient from his county. Suppose he had psychiatric consultation available from the best men in the community and had the hospital available for special examination, special treatments, and emergency assistance. Would he not have a wonderful job? Would not psychiatric service in that community mean something much more than hospital treatment? Would not a few such men, backed up by the community demand, which they would arouse, change the entire complexion of a state hospital?

I know there are administrative difficulties. I know that there would have to be a competent and adequate resident staff. I know that these men with county duties would have divided loyalties. I hope some of them will break away and go into private practice. The only serious difficulty I see is geography. Some hospitals are so far from their source of patients that a physician could not spend adequate time in each place.

To meet the problem presented by distance, a county mental-health officer, trained in psychiatry and in public-health methods, might be stationed in that county. His duties in the county would be similar to those described. His visits

to the parent hospital would be less frequent, but should be carried on according to a regular schedule. He, too, would be part of a psychiatric system that would begin in the community, pass through the hospital, and return to the community again.

This program is not being advanced as a substitute for hospitals. It would improve hospitals by attracting younger men who want to practice all psychiatry, institutional and non-institutional. It would improve hospitals by increasing public demand for hospitals that could be treatment episodes in the life histories of psychiatric patients.

The program is not to be thought of as a substitute for out-patient clinics, parole programs, or boarding care. It would develop and use these facilities to the fullest. Nurses and social workers would inevitably be carried with it. What it should do and what it would do is to develop public psychiatry on a realistic basis, centering it on the patient rather than on the hospital.

None of this can be done without organized, vocal, and informed public opinion. The organization and instruction of such groups is our most important present problem. It presents a challenge to every state mental-hygiene society and to The National Committee for Mental Hygiene, because, if they do not take the leadership, others will and the others will be less well informed.

MENTAL HOSPITALS, 1946 *

EDITH M. STERN

Washington, D. C.

IT is difficult for me to talk to an audience like this because so many of you in it are professionals who know more about mental hospitals than I do. Indeed, even those of you who are not professionals must know almost as much. Recently the man in the street has had every opportunity to learn about the appalling conditions in our state hospitals. He can hardly pick up a magazine without finding one or more articles on the subject. Whenever he is bored with the newspapers for lack of titillating horror stories about concentration camps, he can turn to them for equally horrific stories about conditions in mental hospitals. Thousands upon thousands of lady patrons of rental libraries are intimately acquainted with daily life in a mental hospital because they have read *The Snake Pit.*

It would seem, therefore, rather superfluous for me to take up much time painting the picture of present-day mental hospitals—it would be like gilding the lily, or in this case perhaps I should say blotching the skunk cabbage. Surely I cannot improve upon the colorful wording of such expert journalists as Mr. Maisel or Mr. Deutsch; nor—since as the Chinese say, a picture is worth a thousand words—can I present anything more shockingly graphic than the picture of the naked male patients that appeared in *Life.* Of course that photograph happened to be taken on the worst ward in what is probably the worst hospital in the whole northeastern area, but nevertheless those men were there in that condition.

Indeed, everything you have seen pictured or have read in shocker articles is true. Patients *are* beaten up and murdered by attendants. Patients *are* starved—either because the diet is insufficient or because there are not enough or the

* Presented at the Thirty-seventh Annual Meeting of The National Committee for Mental Hygiene, New York City, October 31, 1946.

right kind of ward personnel to see that they eat what is served. Patients *do* deteriorate in idleness, and some patients *are* cruelly overworked. Patients who might be cured by modern therapies *are* locked up or mechanically restrained, only to become sicker—more introspective or more aggressive. There *are* many antiquated, unsanitary buildings, and there *are* filth and vermin and overcrowding. Even the best hospital I have visited recently was filled 33 per cent above capacity.

Yes, it's all true, and nothing but the truth. But it is not the whole truth. The veracity in fact, but not in emphasis, of the shocker stories, reminds me of the story of the veracity of the ship's log. Every day the captain wrote in it, "The mate was drunk to-day." The mate became a little tired of this notation, so one day, when it was his turn to keep the log, he wrote, "The captain was sober to-day."

I should certainly not deny that our care of the mentally ill is sub-standard and a national disgrace, even though I could point out heartening instances of good living conditions and genuine treatment. But I think I can spend the limited time at my disposal more constructively with suggestions as to what may be the fundamental causes of abuses than with describing in detail the abuses I have seen in hospitals, bad and indifferent. These causes have been somewhat publicized, but merely in a secondary way, and I believe that it is only paralyzing to continue to contemplate horror upon horror. I believe that the piling up of one shocking detail after another results in little more than the reaction, "It's all so terrible and hopeless, where can you begin?"

Actually, each defect in our state hospitals has a specific, remediable cause, such as lack of space or of personnel or of curative facilities. And underlying these causes is, in my opinion, one large general cause—insufficient funds. I agree with J. Rufus Wallingford who said, "Money isn't everything—only about 97 per cent." True, in about seven states there is actual mismanagement, and hospital conditions probably wouldn't be improved by larger budgets. For instance, increased appropriations would not be likely to help the patients of the superintendent who took away their little recreation building and turned it into a coffin factory. But,

on the whole, more money would solve the most pressing problems.

Take the hospital I know best in the state I know best, the state in which I reside and pay taxes—Maryland. It is an excellent state to take as an example because it is neither exactly Northern nor exactly Southern and in pretty much everything is medium, or mediocre. It comes about as near that mythical "average" as is possible.

Now this particular hospital has an excellent superintendent, but he is hamstrung in applying his administrative and psychiatric skills. Hundreds of his patients are kept in mechanical restraint because his attendant staff has 52 per cent vacancies, and mechanial restraint is the only way he has of controlling aggressive patients. And his attendant staff has 52 per cent vacancies because basic pay is $960 a year, and because he has no money to provide his staff with transportation from an isolated place, and because he has no money to build the decent living quarters he knows they need.

Recently a twenty-four-year-old attendant killed an eighty-three-year-old patient. During the trial it was revealed that this young man had been rejected by the army because he was a psychoneurotic, and the *Baltimore Sun* came out with an editorial blast to the effect that attendants ought to be more carefully selected. How much selectivity do you think is possible when vacancies are 52 per cent and basic pay is $960 a year?

It's the same story with food. This Grade-A superintendent is allowed 26 cents a day to feed his patients—and even with the advantages of quantity buying, how would any of you like to feed your families—assuming, too, that some members of them are tuberculous or diabetic and need special diets—on that amount to-day?

Now when we come to medical-staff vacancies, perhaps I'll have to qualify a little on my generalization about money's being the most important factor. Doctors are not like other people. They do not work for money, or to make their families comfortable. They work for love of their profession and of humanity. So perhaps there are other reasons why this Maryland hospital has only four physicians to care for 2,200 chronic patients—and, believe me, with that share of

medical attention the great majority of them remain chronic—and only 14 physicians for a total of 3,000 patients. At that, though this doctor-patient ratio does not compare favorably with the American Psychiatric Association's minimum standard of one physician to every 100 annual admissions and one to every 200 residents, it is magnificent beside that of some other state hospitals. There is one in Kansas, with a patient population of 1,705, that has three physicians. The junior member of this medical staff is sixty-seven and their average age is sixty-nine.

Almost everywhere there are vacancies for physicians. Perhaps psychiatrists would be willing to accept salaries ridiculously low compared to what they could earn in private practice if they really had a chance to practice psychiatry. But in too many of our state hospitals, they have not, and again an all-around lack of money is usually at the bottom of this state of affairs. I talked with an earnest, sincere young psychiatrist who had just left a state hospital for private practice although he was more interested in hospital work.

"I couldn't take the frustration any longer," he told me. "I had 800 patients under my care and I could hardly attend to their physical ailments."

State hospitals are only a very little better off, so far as medical staff is concerned, than they were during their darkest days of the war. Though 900 doctors out of military service, who wanted further training in psychiatry, applied for employment through the agency jointly set up by the American Psychiatric Association and The National Committee for Mental Hygiene, only 60 took positions in state hospitals. A state hospital ought to be as ideal a place to get this training as a general hospital is for postgraduate training in general medicine; only there can a physician consistently see the extremes of behavior that illuminate and clarify all shades of behavior.

In a Brooklyn state hospital which has facilities for real training, and experience in psychiatry, not only intramural, but also in community clinics, there is a full complement of doctors. But you cannot blame the veterans for not wanting to work in most state hospitals, for they know that they cannot get real training there. There is nobody to train

them. Somebody must have enough time to devote to teaching, and for somebody to have enough time for that, there must be somebody not overloaded with patients, and that means that there must be sufficient appropriations to attract sufficient personnel. Quantitatively, even without the qualitative improvement that tends to go with financial inducements, it seems to me as simple as that. I may be unduly materialistic, but before we decide, let us see what happens when all state hospitals—with the possible exception of the roughly one-seventh I mentioned before—have the wherewithal in cold cash.

There is something else, I think, that contributes to the low standard of medical care in too many mental hospitals, and it is too facilely attributed to "mismanagement and cruelty in our mental hospitals." (I quote from an editorial in a woman's magazine which recently got on the band wagon and received such letters from readers as, "You have taken the lead to a more enlightened day." I'm sure the members of The National Committee for Mental Hygiene are glad to know who the leaders in this crusade are.) At any rate, that something else is not mismanagement or cruelty, but the insidious lowering of standards of the administrators and physicians valiant enough to stay on.

Several years ago, when I was preparing an article, *Our Ailing Mental Hospitals,* I interviewed a superintendent who was the first person to explain to me the evils of mechanical restraint. He said, "It should not be used at all," and glowingly described how, when he was a young doctor, he had seen it entirely eliminated—and with great success—in a hospital in which he had worked.

Over the years I have seen that superintendent's hospital grow worse, with increased patient load and decreased staff. I have seen his disturbed-women's ward, with a few patients pacing about, but the majority sitting in long rows in restraint. So they sit day after day; so they have to sit, because there are five attendants for the twenty-four-hour day to care for 130 of them, and no one can see that they get the exercise and diversion and simple occupation that he knows, and you know, and I know, are indicated.

I have seen that superintendent grow grayer and more

harassed-looking, and the other day he remarked to me: "What's the use of kidding yourself. For some patients, you have to use restraint." He is no less sensitive, no less conscientious, no less skilled than he was when I first met him. But I wish I had not remembered the way he used to talk about restraint, because I think the unconscious shift in his thinking is one of the saddest side lights on what is wrong with our mental hospitals that I have ever had.

It is very easy to accuse superintendents of indifference and callousness, but though I am not claiming that they are all angels, I have found that often, when their institutions are inferior, it is because they could not constantly bear to face the discrepancy between what they wanted to do for their patients and what they could do for them, or because they have succumbed to the pressure of their jobs.

I quote from an excellent little publication of the Coördinating Committee for Improving Iowa Institutions: "The superintendent of a state hospital in Iowa"—and this applies elsewhere—"is expected to fill many rôles simultaneously. He must be a qualified psychiatrist to supervise the care and treatment of patients, a politician to maintain the interest of the legislature, an administrator to organize the operation of the hospital, a personnel expert to secure and retain employees, and an evangelist to preach the gospel of mental health in Iowa. . . . Under present conditions the time and energy of the superintendent are consumed by details of routine administration, personnel work, contact with patients' relatives and public affairs. He can spend little time in intimate contact with patients," and so on. Only an exceptional man can rise above these material and psychological burdens and do a really dynamic job.

The same kinds of disheartening factor create nursing vacancies and routinize nurses; there is no use in repeating the dreary recital. When you get down to the attendant level, where there is not even the original stimulus of professional interest, it is perhaps worst of all. I was talking one day to a young woman attendant who had been pointed out to me as one of the best in her hospital.

"I know they need me here," she told me, "but I'm quitting. I can't take these ten-hour days and all the work any longer.

Why, this afternoon I'm scheduled to give bed baths to one hundred old women!''

Of course sadists, and alcoholics, and just plain bums take and get jobs as attendants. But most attendants are simply overworked, untrained, frightened, decent people who do the best they can, and too often that is not good.

Obviously, with certain exceptions, I do not see the personnel of our state hospitals as the villains in the case. Is the villain, then, politics, as has often been stated? I doubt it. In some states the mental hospitals are political footballs and corruptly and incompetently staffed for that reason. But in most they are not. With to-day's booming and zooming economic conditions, jobs in state hospitals are not such plums that the politicians bother much about them.

It is, rather, a concatenation like the House that Jack built. Lack of appropriations creates conditions which in turn create lack of sufficient and qualified staff, and that lack in turn creates lack of good care and of the real therapy that would send the majority of patients out again into the community instead of maintaining them wretchedly incarcerated.

Now suppose we consider why the appropriations are so scanty when millions of state dollars are thrown into parkways and research on diseases of cattle and building state capitols. Again perhaps I am oversimplifying, but it seems to me that it is because of a combination of public ignorance and indifference.

The ignorance one certainly cannot blame on the journalists. They have done their best to dispel it. But I differ with the exposé methods now in vogue, because I cannot see that a shock and a shiver add up to education. The morbid devouring of gruesome details of abuses does but little, I feel, to alter the average person's basic revulsion against the mentally ill, and hence his indifference to their plight. I do not need to explain here that we all tend to shove aside what we find unpleasant. The mentally ill are unpleasant—so we shut them up where they can't get in our way, in some big building with beautiful grounds, far off in the country where we won't be annoyed by their screams, and that's that. Not until the taxpayers feel it in their minds and in their hearts and in their bones that the mentally ill are simply sick people,

who have as good a chance of being cured as most other sick people, will we get sufficient appropriations to give them the kind of care and treatment they need.

An organization like this, of course, is working to that end, and many members of it are psychiatrists. But psychiatrists as a group, I think, are guilty of great sins of omission in their public relations. Despite the fine public relations achieved by General Menninger's division during the war, psychiatrists have not sold themselves and their achievements sufficiently to the lay public.

On the other hand—though I do see an encouraging trend to throw open the doors of state hospitals for investigation—I have found that too many superintendents try to conceal the deficiencies of their institutions. I have had a number of amusing experiences along this line. On one occasion I had an excellent lunch in the nurses' home and commented that it was the best meal I had ever had in a state hospital. Later, when the head nurse introduced me to the superintendent, in a very pleased tone she repeated my remark to him. He beamed and said, "Yes, the patients enjoy the food, too."

It wasn't very polite of me, but I couldn't resist saying, "Oh, but they don't get the same food. I saw *their* lunch!"

Dead silence followed. The patients' lunch—or, rather, dinner, for it was their main meal of the day—consisted of two slices of bread, a mound of mashed potatoes with brown gravy, one hard-boiled egg in the shell, and a cup of milk.

Again, on a very hot day, when I was going through a hospital with its superintendent, I saw a poor little woman ironing a huge pile of clothes. The superintendent observed jovially, "This is occupational therapy." The patient looked up at him and said wryly, "In a way," and again silence fell.

Scanty though mental-hospital budgets are, I think it would pay every state many times over to employ a part-time public-relations expert for each hospital, to keep the public acquainted with whatever is going on, for better or for worse. Every business man knows that you have to spend money to get money, and a frank and consistent information policy would be better than camouflaging attempts by administrators or trusting to the not-so-tender mercies of the press when conditions get so bad that there is an open scandal.

I believe, too, that every state hospital should have a program of conducted tours, to which civic groups, women's clubs, and indeed individuals should be invited. These should be preceded by careful indoctrination in the form of a short introductory lecture before the tour or some simple literature. I recommend as a project for The National Committee for Mental Hygiene the publication of a pamphlet with a title something like, *What to Look for in Going Through a Mental Hospital.*

I do not believe it is worth the time expended merely to escort legislators or interested citizens through a hospital, because too much escapes the uninformed. I am no expert, but even I, when I visited a state hospital recently, because of some background in this field saw many things I was not shown. Physically it was a beautiful and attractive place; all the patients I saw were clean and well dressed. In fact there was nothing wrong with the place except that practically nothing was being done for the patients. A beauty parlor was displayed to me with pride; it had two chairs and no professional operator, and though the hospital had about 1,500 women patients, not one was in it. Neither were there any patients in the magnificent hydrotherapy room. There was no occupational therapy, no recreational program, very little shock therapy. The only form of exercise I could discern was floor mopping.

Some one said to me, "One good thing, here in this state, the legislators do come and visit the hospitals." I pointed out that they might as well not come, for to the average legislator, here was undoubtedly a perfect place, as attractive as a summer resort, and immaculate. In order to see what was wrong with that hospital—what was very wrong—it was necessary to have therapeutic rather than custodial concepts, and I doubt whether the run-of-the-mill legislator is imbued with these. But take him through with a "This should be done," and a "This is not being done," and "This is our discharge rate," and "This is the discharge rate of a first-class hospital," and surely he would see the picture and the needs more clearly.

Another hazard of taking through people who are given no preliminary information is that they are also likely to

see some things as worse than they really are. For example, the uninformed do not realize how difficult it is to keep certain types of patient decently clean and dressed at all times. They may mistake a healthful letting off of steam, in the case of a sensibly treated disturbed patient, for untrammeled and neglected violence. A superintendent once said to me indignantly: "See that catatonic facing the wall? He's getting treatment, and he'll be all right—but some of those newspaper fellows would come in and say he ought to be playing the piano."

Much help in informing the public about good and bad treatment of mental patients should be coming along Q.E.D. lines through the new National Mental Health funds. Dr. Felix has plans for units from the United States Public Health Service to go into buildings in state hospitals and for a period to demonstrate what can be done for patients. Not only will the hospital staff benefit by the example, but also it will serve as evidence for legislators and the community in general. The difference in the appearance and behavior of patients on the demonstration ward, for example, can be tellingly compared with a control group of patients on a ward that has gone along as before. So can discharge rates. The only thing holding up this project is lack of personnel. Work with it seems like a challenging opportunity for any professional, and it affords the double satisfaction of direct work with patients and public health service.

Something else is going on that, though highly desirable in itself, is, I fear, more of a hazard to existent state hospitals than a help. I refer to the increasing trend toward the establishment of receiving hospitals and psychopathic wards in general hospitals in which prompt and intensive treatment is given. Already such treatment centers are attracting personnel away from state hospitals. We must be on our guard lest the state hospitals come to be considered nothing more than dumping grounds for hopeless cases, and become even more custodial and inferior than they are. It would be fine if no one from now on ever needed to go to a state hospital, and if every mental patient recovered after a few weeks or months in a psychopathic ward. But that millenium has not yet arrived, and even if it had, there

will still remain pre-millenium men and women in state hospitals, and they are entitled to continued treatment. In psychiatry, as in other branches of medicine, while there is life there is hope, and only for a small proportion of mental patients, such as seniles, is prognosis so poor that little more than kindly care is indicated.

We must also make certain that the victims of mental diseases are not overlooked in the public's new interest in preventive mental hygiene. Because there is research on the prevention of infantile paralysis, there has been no let-up in the care of children crippled by the disease, and the situation should be similar in the case of the mental illnesses.

We, a group like this, have a great responsibility. We must never cease hammering in these basic concepts: that the mentally ill are sick people, curable like other sick people; that money spent upon them is well invested because it is uneconomical to give only custodial care; that mental illness is not remote from any one, because it touches some member of one in every five families and one in every twenty individuals.

We must not let the public and their representatives in state legislatures ever comfortably forget not only what is wrong with our mental hospitals, but also what should be right in them and how that can be achieved. We must work radically, in the true sense of the word, attacking not symptoms, but their causes.

MENTAL HYGIENE IN THE DISABLING DISEASES*

MORTON A. SEIDENFELD, PH.D.
Director of Psychological Services, National Foundation for Infantile Paralysis

MAN as a dynamic being does not ordinarily react favorably to any process that reduces his capacity for self-satisfaction or that, to put it another way, makes him more static. Such a process tends to occur whenever an accident or a micro-organism produces a disability that results in a permanent or semi-permanent loss or impairment of normal bodily function.

From a psychological point of view, this presents the area in which are developed conflicts of the sort that Masserman has described: "When, in a given milieu, two or more motivations come into conflict in the sense that their accustomed consummatory patterns are partially or wholly incompatible, kinetic tension (anxiety) mounts and behavior becomes hesitant, vacillatory, erratic, and poorly adaptive, (*i.e.*, neurotic) or excessively substitutive or symbolic (*i.e.*, psychotic)."[1]

Thus the problems that present themselves in connection with the prevention of the development of anxieties and maladjustment in the disabled offer an unusually challenging situation for the physician, the social worker, and the clinical psychologist. Here indeed is an area in which prevention not only is feasible, but also can begin, in most instances, with the initial contact of patients with their physicians.

Since this task is in most cases a long-drawn-out process, and may be expected to consume a great deal of time each day, it is hardly likely that the physician can or will devote adequate attention to it. In most instances, he will delegate this task to the professional workers on his staff who are best prepared to carry it through to fruition. Whenever they are present, psychologists can and should play a major

* Presented at the Seventeenth Annual Meeting of the Eastern Psychological Association, Fordham University, New York, April 26–27, 1946.

[1] See *Principles of Dynamic Psychiatry*, by Jules H. Masserman. Philadelphia: W. B. Saunders Company, 1946. p. 122.

rôle in such a program, since they possess the type of training that equips them for dealing with it. As a rule, however, it is a coöperative endeavor, and the physical therapist, the occupational therapist, the nurse, and the social worker should be in the line-up of the team supporting the psychologist and the physician.

It is the aim of this paper to indicate briefly the approaches that may be used by the workers who are responsible for carrying on preventive mental hygiene.

Early Appraisal of the Patient and His Reaction to His Illness.—A general rule regarding the patient's initial reaction to his illness cannot be offered. At most we can anticipate that the patient will view his illness with fear at the start, and that this fear will become greater or less depending upon the extent and the promptness with which the disease and its effects are brought within the realm of his understanding. Even when, as is generally true, the ultimate prognosis must be guarded, it is possible to provide the patient with enough information to correct any erroneous impressions and fear-producing "bugaboos." This task depends initially on the physician, but may be furthered by others in contact with the patient. The physician should acquaint the nurse, the social worker, and the psychologist with the facts in clinical conferences.

At present too many patients are allowed to suffer anxieties that are avoidable. As Wallin has stated, "It is well known by workers with physically handicapped children that frequently their worst liability is not the physical handicap to which they are subject, but the personality maladjustments which have arisen as a result of their mental reactions to their handicaps." Wallin continues, "Frequently the attitudes and maladjustments that result are due not so much to any direct effect of the disability as to the attitude assumed toward the underprivileged one by the parents, teachers, siblings, or playmates. This is true whether the treatment takes the form of coddling and overprotection or of disparagement, ridicule, or application of jocular or sarcastic epithets."[1]

[1] See *Minor Mental Adjustments in Normal People*, by J. E. Wallace Wallin. Durham, N. C.: Duke University Press, 1939. p. 230.

The implication of this criticism is that thus far the physician and his co-workers in the fields of nursing, physical therapy, social service, and psychology have overlooked to a great extent the importance of preparing the patient, the family, and the friends to accept the illness and its sequelæ with understanding and realism.

The early explanation of the nature of the disease, what it may be expected to do, the extent and degree of recovery that may be anticipated—with emphasis placed upon what may be expected as a minimal recovery and what may happen if optimal conditions can be attained—may all be presented to the patient and his parents. This can be done not only by the physician, but by qualified professional workers in the medical ancillary fields. In addition, evidence of erroneous concepts and maladjustments should be sought out and corrected.

Obviously this can obtain only when the physician has been made cognizant of the values to be attained by such practices. This means that psychologists, already working in environments in which such understanding approaches exist, should seek objective and subjective data supporting any claims to improving the patient's lot by such techniques. There are still many physicians who may feel reluctant to discuss such matters except with other physicians. Many may feel that the ancillary workers cannot be allowed to speak of these matters with parents, friends, or patients. If they hold to this doctrine, however, they must become aware sooner or later that, in the interest of patient welfare, mysticism should be removed. It is only through utilizing properly trained workers who are in constant contact with the patient and his environment that this can be accomplished.

Thus, an effective program of staff conferences between the physician and his co-workers will result in each representative of the physician impressing on the patient, and on those who are interested in him, the realistic facts and the plan for the future that will yield as nearly a complete return to normal as possible. In this manner, physical therapy induces a motive for coöperation in the patient, who views it as one element in getting well—not merely as the treatment of a collection of muscles and joints, but as part of the care

of the total integrated personality. The occupational therapist becomes an aid in the drive to be able to satisfy ego demands. And the psychologist is an objective appraiser who will help Johnny Q. Patient to reëvaluate his assets for to-morrow.

Early Appraisal of the Patient's Psychological Capacities.—As has been indicated above, initially it is necessary for all who work with the patient to coöperate in the correction or the removal of attitudes that are inimical to the patient's recovery. More than this must be done. We must give to the patient some positive values to strive for, in order that his motivation may not be damaged or destroyed.

Here the psychologist can play a fundamental rôle. Once the physician has appraised the extent of the damage wrought by the disease process, he can indicate to the psychologist what may be anticipated in terms of immediate and ultimate recovery of function. Some concept of the maxima and minima of potential recovery should be sought, so that an appraisal of potentialities will be realistically approached. This should be based, in so far as practicable, upon such objective standards of functional attainment as those set up by Dr. George Deaver and his colleagues at the New York Institute for the Crippled and the Disabled.[1] Once we know or can anticipate the return of certain fundamental activities to the patient, such as the ability to move about (with or without mechanical aid), the capacity to utilize eating utensils, to dress himself, and to get to and from one place or another, we can then set about determining motivation, aptitudes, interests, and the like, which are fundamental to total readjustment, and establishing a planned program of socio-economic orientation.

The psychologist should direct his attention to ascertaining those psychological characteristics that are intact and that have suffered little change as a result of the illness. These may be looked upon as foundation stones in establishing a prophylactic depot upon which one can base the initial training of the patient. In most of the disabling diseases—excepting, of course, those involving cortical damage—the intellect is left relatively intact. We can, therefore,

[1] See *Physical Demands of Daily Life*, by George Deaver. (Studies in Rehabilitation No. 1.) New York: Institute for Crippled and Disabled, 1945.

begin training that allows the patient to utilize this capacity rather early.

The difficulty of the task, needless to say, should be pitched at a level commensurate with demonstrated capacity. In the early stages at least, the likelihood of success should be very high. Likewise, those physical activities which remain intact, and of which the physician permits early utilization, can be called into operation—not only for purposes of physical therapy and occupational therapy, as separate entities, but also as meaningful activities. They can be *made* into meaningful activities by the simple expedient of having the psychologist coöperate with the physical therapist and the occupational therapist in making clear to the patient that the activities represent steps toward reorientation and adjustment to ordinary living.

The importance of putting such a program into effect promptly cannot be overstressed. As Bluemel has said in discussing the tendency of the sick to developmental sequelæ to physical illness, "Preoccupation is accompanied by the various physiological disturbances which characterize the deeper emotional state."[1] There are too many patients who are allowed to languish in bed, presumably recuperating, but actually devoting their efforts to "stewing in their own juice."

It is an interesting fact that many physicians still pay little heed to psychosomatic medicine. Yet when one deals with problems of the poliomyelitic, for example, it would seem highly important to be aware of such problems as are concerned with muscle tension in the musculature that has been directly affected and the non-affected muscles as well. We may say with Dunbar, "Muscle tension is of fundamental importance as an expression of the personality's habitual defenses."[2] Can one expect to obtain patients' relaxation merely by putting them to bed and telling them to relax? Those who treat the tuberculous, the cardiac, or the poliomyelitic and the encephalitic know that mere verbal directions or physical provisions for such relaxation will not accomplish that end.

[1] See *The Troubled Mind*, by C. S. Bluemel. Baltimore: Williams and Wilkins, 1938. p. 193.

[2] See *Emotions and Bodily Changes*, by Flanders Dunbar. Third edition. New York: Columbia University Press, 1946. p. xxix.

Correlating Medical Programs and Psychological Findings.—Once the psychological appraisal of the patient has been made, it is essential that this information be correlated with the medical findings. This can be done best by the conference technique, in which the psychologist presents his findings—along with those of the physical therapist, the social worker, and so on—to the physician. All will indicate to him what his patient has to offer in the way of assets, and how these assets might be used in meeting the patient's own desires and plans. In some of the planning the physician may conclude that the suggestions, were they carried into effect, might be harmful or risky for the patient. Here, he will recommend the necessary modifications. Other compromises may be required, based upon social-service elements, personality factors in the patient, parental opposition, and so forth. However, the end product of the conferences should be the establishment of a plan of operation that will as nearly as possible fit the needs of the patient to his physical, psychological, and socio-economic potentialities.

Under even the most adverse circumstances, such a program would yield the patient the assurance that careful scrutiny has been given his future and that what is offered him in the way of physical therapy, psychological study and investigation, and medical care in general, is designed actually to return him to a useful and happy place in his own social group.

This is no Pollyanna technique, but is aimed at placing the reconstruction of the physically limited individual on an objective basis.

Not only does this serve the interest of the patient, but it considerably simplifies the task of making clear to the parents the direction and scope of the treatment and the end result that may be anticipated not only in the matter of medical care, but also from the social and the psychological points of view. The parents can be taught their rôle in the ultimate reorientation program. By planning such training early, parents are encouraged to recognize their rôles and their responsibilities in the process of getting their child well. This is in contrast to the old idea of passing the problem on to the parents only when the patient is due to leave the hospital.

Development of a Program of Training, Work-Tolerance Building, Job Placement, and Socio-Economic Reorientation. —Based upon experience, it is apparent that the most satisfactory prophylactic techniques in preventing the development of grossly disoriented personalities are those that begin as promptly as possible after the onset of a disability of permanent or prolonged duration.

In presenting the problem from the standpoint of the individual, it is essential to include an adequate explanation of the physical as well as the mental capacities that remain intact; those that are reduced at the moment, but that may be expected to return to normal or nearly normal levels within a period of time; and those that are unlikely ever to return to a sufficient degree to justify planning for them.

To accomplish this it is necessary, of course, for the physician to recognize that in the interest of the patient it is desirable that he select and explain the prognosis, so that the patient may be fully aware of "what it will take" to regain and maintain an acceptable socio-economic status. Even when the prognosis must be guarded, it is still better than leaving the patient with nothing more than his own imagination as a guide to what the future holds for him. Such guesswork fails to stimulate an interest in learning how to live with deficiencies that the patient cannot explain or interpret as to extent and permanence.

The application of such a program will yield results in the prevention of anxiety and insecurity feelings. When the patient is apprised of his situation, he is able, realistically, to make plans for a life based upon the physical and mental equipment at hand. He also can avoid the development of euphoric concepts or pessimistic underestimation of his rôle in his milieu.

Obviously the maximal values in such an approach are to be found when they are applied early enough to prevent the development of misconceptions, frustrations, and uncertainties. The physician who works with the psychologist, the social worker, the physical therapist, and the occupational therapist, in carrying on a drive to prevent maladjustments, will be surprised to observe the optimal physical improvement by the patient.

SOME ESSENTIALS IN NATIONAL MENTAL-HEALTH PLANNING*

DANIEL BLAIN, M.D.

Chief, Neuropsychiatry Division, Veterans Administration, Washington, D. C.

WITH eight million people[1], 6 per cent of the total population, suffering from some form of mental disease or personality disorder, the branch of science devoted to that group of diseases finds itself facing an overwhelming responsibility. And since the six to eight million families of these people are affected by their sick relatives, a large and important portion of the total population being thus profoundly disturbed, the problem becomes one not only of medical science, but of all groups of society.

Accounting for over half of all hospital beds in the civil population, and the larger part of the medical and disability discharges from the armed forces, psychiatric conditions are obviously swamping the medical profession. Psychiatry and the medical profession—and I include all specially trained auxiliary groups in the medical profession—are in both an enviable and a dangerous position to-day. Faced with the task of stemming a rising tide, they have a glorious opportunity for national service. If, however, they fail to exert leadership and to deal successfully with mental diseases and maladjustment, the prime responsibility will be taken away and will fall into the hands of others.

The problem is of the group rather than of the individual. While the original causes of the major mental diseases are still unknown, we believe that they are aggravated by the stresses and strains of life. They, however, are the minority of mental disorders. The psychoneuroses constitute the far greater number of these disorders and a good deal is known of their etiology. No illnesses are so related to the interplay

* Presented at the Seventy-third Annual Meeting of the National Conference of Social Work, Buffalo, New York, May 21, 1946.

[1] From the hearings on the Neuropsychiatric Institute Bill and Social Security Board (private communication).

between the individual and his environment as those in the mental and emotional field. Conflicts within an individual are related to repression of one or another instinctive drive. These are profoundly affected by the cultural and ethical patterns of the family, and the *mores* of the community. Difficulties in the realm of interpersonal relationships obviously are influenced by others besides one's self. The neuroses, therefore, cannot be handled without reference to the community at large, and are closely connected with the state of the group or the nation. Ulysses said, "I am a part of all that I have met," and just so the neurotic reaction is made up of all of life's experiences. With this in mind, it is appropriate to speak of national planning for mental health—since any plan to eradicate mental and emotional illness must be national in scope, in distribution, in size, and in importance.

It is well at this point to suggest an orientation toward the problem that I believe is important. Our attention is traditionally focused on the 6 per cent who are sick. It is the 94 per cent who are well who are the most important. Mental health is more important than mental disease. Viewed without sentiment, healthy people are more important than sick people. There are more of them; they do their share of the world's work, produce enough in excess of their own needs to provide for children and the aged; and they care for the sick. It is in changing sick people into healthy people and in keeping the healthy from getting sick that medical science finds its chief reason for existence. Planning for mental health, therefore, must emphasize the positive concept of *health* rather than the negative concept of *disease.*

The Veterans Administration has among its beneficiaries a large portion of the adult male population. Its psychiatric problem is quite similar to that of society in general, in that 60 per cent of its beds are devoted to neuropsychiatry, and three out of five claims for disability pension are neuropsychiatric in origin. Neuropsychiatric hospitals now contain about 50,000 patients. It is estimated that 200,000 beds will be needed by 1975, at which time the peak load should be reached. Estimates of those who need out-patient care are vague, but are based on the 581,000 discharges from the services for mental condition and inaptitude. In a survey

just completed in a small Eastern state, the psychiatrists who made the examination were of the opinion that out of 2,600 veterans who were receiving pensions for psychiatric disorders, over 50 per cent needed out-patient treatment and would have benefited from it. This means 1,300 veterans, or 2 per cent of the entire 64,000 who returned from World War II. It is estimated that 100,000 need treatment now. How this number will increase or decrease, we cannot say. Since every available mental-hygiene clinic is operating to capacity, no ratio of the number of patients to a given population unit can be demonstrated.

In the last few months, efforts have been made in the Neuropsychiatry Division of the Veterans Administration, not only to handle the immediate hospital emergencies, but to lay a broad and solid foundation for effective work over a period of years. It is natural that in the course of these efforts certain ideas should have emerged and become crystallized into policy. They serve as guideposts in our planning. Although the federal government has by Congressional action fixed the responsibility for 20,000,000 veterans on the Veterans Administration for service-connected disabilities and for hospitalization of non-service-connected illness under certain circumstances, the very nature of mental disorder precludes independent planning. The shortage of all facilities indicates the necessity for a sharing of all assets—just as the general causes that operate to produce neurosis are common to all members of the total population. Veterans are a part of the general population. Efforts on our part toward care and prevention will be of no avail unless they are matched by similar efforts throughout the country. National planning, therefore, is even more necessary from the standpoint of the Veterans Administration, to aid us in carrying out our responsibilities.

National planning for mental health has been haphazard and piecemeal. For a comprehensive study of certain aspects of the problem, I recommend the symposium entitled *Mental Health* held under the auspices of the American Association for the Advancement of Science, and published in book form in 1939. Unfortunately, the great increase in mental disorders brought on by the war, and the sudden discovery that

an alarming part of the population was unfit for military service, came after this study, showing large gaps in its coverage of the total problem. It still remains the best compendium to date.

Dr. Robert Felix, Chief of the Mental Hygiene Division of the Public Health Service, anticipating the passage of the National Mental Health Bill, has presented a plan of national scope.[1] He lists five points on which to attack the problem—(1) research; (2) training of personnel of all types; (3) additional out-patient clinical facilities for prophylactic and early therapeutic work; (4) better care of the hospitalized patient; and (5) education of the public for better care of convalescent patients and of themselves.

We in the Veterans Administration are interested in giving good medical care and all that that implies. We are now working for the improvement of present hospitals as regards more personnel and better equipment; for new hospitals with the most up-to-date architectural plans, located in areas near medical schools and associated with them; for the creation of a chain of mental-hygiene clinics adequately staffed with social workers and clinical psychologists; and for arrangements with all grade-A medical schools to start postgraduate training for specialization in psychiatry. We have about one hundred residents now and hope to reach from six to eight hundred within a year. Almost all Veterans Administration hospitals and mental-hygiene clinics will be made into teaching centers. Money is available for research both of clinical and laboratory type.

In facing a desperate situation filled with emergencies, with critical shortages in personnel, we have found great deficiencies in knowledge and very little leadership on which to lean in solving a whole series of major problems. With billions of the people's money going to be spent, it is an awful obligation to see that it is spent wisely. With thousands of our best young men needing immediate treatment, we are impressed with the necessity that methods and techniques shall be right—that these men shall not say years later: "If I had only been treated in time! If I had only had

[1] In an address before the Ohio State Society for Mental Hygiene, January, 1946.

something better than was offered—I would not be as I am now!" So we are asking ourselves many questions. Our suggestions for national planning come in the form of queries. I am not giving the answers. I am putting up to you and other responsible groups the task of shaping this plan. You will see where we are puzzled and looking for help.

1. What is the real nature and extent of the psychiatric problem of this country? This demands a thorough, comprehensive survey. No effective plan can be devised until the problem is defined, understood, and evaluated. No one is satisfied with our present knowledge. Statistics are uncertain, often based on changing nomenclature. The emphasis has been on psychotics, yet the great burden of the load is in the field of the neuroses and maladjustments. The extent of these is almost completely unknown. Past figures have come from hospitals where professional skill was often inadequate and little definitive treatment was carried on, custodial residence being about all that was afforded. Have we any data on large numbers of patients, in any category, for whom vigorous treatment was begun early, under proper conditions, and carried on to completion? These data are found in only a small percentage of hospitals.

What do we know of the extent and nature of mental disease and personality disorder in children, in young and aged adults, and the relationship of one to the other; of the reactions in various races found in this country; of the effects of the national strains that have mixed to form the average American? Have we any comparison between those who are rich, poor, and intermediate; between the literate and the illiterate; between those of superior and those of lesser intelligence; between the urban and the rural; between the hot and the cold parts of the country; between the various groups of workers—farmers, miners, seamen, white-collar workers, day laborers, migratory groups, tramps?

Much could be gained by comparing our situation with that in other cultures, studying the effects of fatalism, comparing the incidence and nature of mental disease in countries dominated by various religions, such as Buddhist, Mohammedan, Christian. I have been told that there is no mental illness to speak of in the Near East. Is this true, and

if so, why? Does the youth or age of a country have a bearing on the precipitation of mental disease? Are we softer and more vulnerable than in pioneer days? Do the enthusiasm and grandiose ideas of those from a pioneer state like Texas, added to the superior wealth and natural resources of the state, make Texans more immune to neuroticisms, or less immune?

What about national trends? Do they affect the incidence of nervous breakdown? Are rugged individuals tougher than the proponents of a "strong White Father in Washington" who gives security to all? Is the modern concept of welfare work as found in the policies of the Social Security Board as good as it appears to be, or should we expect further modification with the passage of time? Are backers of free enterprise different in emotional make-up from advocates of totalitarianism?

Is it possible to retreat from freedom into slavery, pushed by freedom-engendered anxiety? Is the freedom of the individual, inherent in the democratic process, a source of greater emotional conflict? Is there such a thing as a national psychosis, or neurosis, or hysteria? Is it not true that we are now in a state of hysteria with conversion (or non-conversion) symptoms? Is there a true epidemiology of behavior? Can a nation be drunk with power and success and suffer a national hangover, or go into a state of mania, perhaps induced by hidden anxiety over success and its implications? Is business in a state of suspended animation, or is it paralyzed by neurotic fear caused by the failure of leadership? Or are we all merely exhausted?

I am suggesting that we learn more about what is called the group; that we integrate the work of anthropologists, sociologists, psychologists, concerning mass reactions; the effects of interpersonal relationships; the effects on man of belonging to a society and how the intimate details of that society, with its inheritance, its *mores*, its protective mechanisms, affect men singly or in large numbers.

We should know the various factors that operate to influence or to produce mental disease and personality disorder.

A comprehensive survey of all factors such as those mentioned above should be planned to extend over a longitudinal

section of the nation's life. It should be in the hands of a committee of experts, representing all phases of society. It should work for five or ten years and come out with reliable information.

2. What are the available assets? An early part of a planning program would be a study of available assets. All hospitals in the country—state and federal and private—should be surveyed to determine exactly what is going on. It would be valuable to get together the good points and the bad points of existing institutions—to see what is needed to bring them up to a set standard, in equipment, personnel, treatment methods. Perhaps a coördinated effort would succeed better than isolated individual efforts. Such a coördinated drive might produce an increase in state and federal appropriations—certainly it would aid in a proper sharing of what little personnel and money there is. Duplication in special projects could be prevented, greater teamwork could be inaugurated, more personnel trained, and better care of patients achieved. If the present method of cost accounting could be changed from cost of patient per day to cost per patient per treatment period, it would be shown that economy that prevents adequate treatment and produces permanent hospitalization is false economy in the long run.

3. What are the functions of each of us in solving the problem? We need to fix the responsibility and functions of all who are concerned with the sick. In long-time planning for mental health, it is important to know who is responsible for carrying out any plans that may be devised. Does mental disease belong with tuberculosis and venereal disease as a major public-health hazard, to be turned over to the state, as they are? Should mental health be the responsibility of government, professional, or volunteer organizations, or of individual doctors? If government, should it be federal or state or county or municipal? Among organizations, one thinks of specialty groups, representing psychiatry, neurology, psychology, nursing, social work, and similar organizations, physical medicine, occupational therapy, dietetics, also the National Educational Association. There are the two great volunteer groups—The National Committee for

Mental Hygiene and the new National Mental Health Foundation. Alcoholics Anonymous is making a great contribution in one field. There are the great foundations, contributing to medical problems of their own choice. There are the great religious bodies exerting a profound influence on human behavior and welfare; the fraternal groups—the Mason, the Knights of Columbus, civic groups, veterans' organizations; the great bodies of organized labor and the rapidly organizing employer groups with their interest in the welfare of their constituent members.

The individual doctor, nurse, social worker, and psychologist will always take care of individuals, and be aided by laymen from all fields. Perhaps one rôle of national planning will be to provide more individual workers, build a framework for their coöperative efforts, and see that these efforts are related to all groups in contact with the patient.

Wherever the responsibility lies, there is little evidence of coördination of the force and ability that are available in all these powerful organizations. More and more apparent becomes the absence of leadership and guidance in the development of a drive for mental health. The only exception is The National Committee for Mental Hygiene. Coöperation is relatively easy to obtain, as everybody wants to help. Coördination is more difficult, for this requires a jockeying of forces, frequent giving way to the other fellow, an ironing-out of important differences in points of view and methods.

4. What are the proper functions of various professional groups? Much clarification is needed with regard to the problem of who is authorized to treat mental disease and personality disorder. The present status of those assuming a therapeutic rôle is confused. Doctors are legally entitled to practice medicine and surgery—these terms include all specialties in the medical profession. And in some states psychologists are licensed to engage in private practice, the nature of which is not well defined. Others also are interested in treatment phases, especially in psychiatry; social workers and psychologists feel that they should be assigned a therapeutic rôle and not be treated as technicians only.

It is obvious that the real pleasure in medical activities is

in the patient-doctor relationship and in having a share in working with the patient directly. This is understandable, and should be recognized. Doctors are accused of holding to the position that they alone should treat diseases. This is unjustified and entirely unrealistic. Especially in psychiatry, it is well known that all contacts of the patient affect him favorably or adversely. Many factors besides the doctor contribute to the eventual outcome. Many patients are treated by individuals without M.D. degrees and many do well—just as many, working with doctors, do not do well.

A realistic view must be taken of these things, but for the sake of honesty and ethics, the proper rôle of each person should be carefully outlined. In the Veterans Administration we have arrived at a decision as to what part in the therapeutic process is to be assigned to clinical psychologists and medical social workers. The essence of the position we take lies in the training and experience and ability of any individual clinical psychologist or social worker. I believe that responsibility should cut across professional lines and be based on the solid foundation of individual training, experience, and ability. We recognize the position that each worker desires, assign a share of therapeutic responsibility, and place limits on the extent to which non-medical people shall go. The doctors make the decision as to when to delegate responsibility because under present laws this responsibility rests with us.

The long period of training and the doctor's position under present laws places him in the strategic position that he now holds. People have always looked up to doctors, chiefly because of the large percentage who are unselfishly interested in the good of the patient. But there are signs that the medical profession is not exerting the leadership to be expected of it. Certainly medical people should be out in the forefront in organizing all people who might be brought into a helpful relationship to the problem of psychiatry—to help each group find its proper rôle, and to aid in the development of all the contributing groups for the common welfare.

5. What is the value of the team concept? A most important concept in modern psychiatry is the use of teamwork in

giving the patient "good medical care." Modern diagnosis and therapy are not best accomplished by an individual psychiatrist. All patients need careful social-service and psychological work-up and follow-up. Nursing is essential in hospitals, and the visiting nurse outside. A skilled psychiatrist who knows the functions of the nurse, the social worker, and the clinical psychologist, and who has some experience in group work, can adequately handle five to ten times as many patients as he can alone. Not only can he care for more, but the quality of the care is markedly enhanced.

Outside of the inner circle of four I have mentioned, the team also includes all the groups of people who come in contact with the patient—in the hospital, gate keepers, guards, receptionists, volunteers, those in occupational therapy and physiotherapy, recreation specialists, the families of the patients; in clinics, essentially the same groups, with emphasis on the homes. All members of the team need to be brought consciously into the picture, trained, and assigned to their proper rôles.

Teamwork implies (1) coördination of all the persons participating in the therapeutic effort; (2) recognition of all persons who come in contact with the patient as actively aiding or retarding his improvement; (3) a clear understanding of the function of each member of the team both in his own mind and in that of the doctor, and then assignment of each person to his rightful place; and (4) leadership by the doctor in all phases of this mutually coöperative effort.

6. Where does psychiatry belong in the field of medicine? Any plan for meeting the psychiatric problem of the nation should include the proper orientation of psychiatry in the medical world. Modern concepts in psychiatric treatment call for less isolation, more participation by men in other specialties, more emphasis on early acute treatment, more of what in the war has been called rehabilitation to start with earlier phases of convalescence. As more and more emphasis is placed on psychosomatic conditions, it is more than ever necessary for psychiatrists to be in close contact with all branches of medicine and surgery. This makes for better psychiatry, better medicine and surgery, and better doctors in all fields. Therefore, fewer neuropsychiatric hospitals

should be built and none should be in isolated areas. All general hospitals should have treatment facilities for psychotic and psychoneurotic patients. All mental-hygiene clinics should be part of and associated with general-medical and surgical clinics.

Furthermore, all doctors should have a great deal more psychiatry in undergraduate medical schools, and all postgraduate specialization should include a large amount of psychiatry, even in the sub-specialties of medicine and surgery. This is necessary because of the emotional involvement in all medical and surgical conditions. General practitioners, in particular, should have considerable training in psychiatry. They probably see the bulk of nervous cases, and almost always see them first. They should not refer all such cases. Many should be handled in the general practitioner's office, and they do better that way, if he has some special knowledge to back up his usually great supply of common sense and interest in his patient.

7. What is the importance of a teaching program? It is recognized that the best hospital care is found where teaching is going on. This may be because more thoroughness and intellectual curiosity is found in those who like to teach, though it is not always true, and some academic-minded people are not good clinicians. Probably it is the pressure of young, vigorous, inquiring minds that stimulates the doctor to exert his best efforts. All psychiatric hospitals should be near medical schools and should have an active teaching program. Those now in isolated areas should import, on numerous occasions, leaders in various fields of medicine to keep the staff on their toes and aid in their advancement. Each hospital would do well to establish a teaching position, and in this position, to place a doctor with teaching experience, who would correlate all teaching and special studies and clinical research. In the Veterans Administration we are happy to say that all the above ideas are incorporated. Residencies and staff training are rapidly entering the great majority of our hospitals. We are affiliated with medical schools everywhere, and we have placed good teachers in many hospitals already.

8. Where can we find the people to do the work? The need

for more personnel is now an old story. One wonders why the sudden shortage. The army has dwindled to insignificance, and most men and women are back in civilian life. Most war factories are closed, yet we are short of workers in nearly every category. Certainly many are tired and exhausted from the war effort and are not as productive as before, but this of course is temporary. I believe the answer lies partly in the increased recognition of the value of trained specialists, brought on by the war. It lies also in the increase in psychiatric disorders now brought to our attention, and in an increased desire to take better care of medical and related problems throughout the country.

Long-time planning probably will show the need for a greater number of graduates in all the specialty schools. It will call for a much greater relative increase in the teaching of psychiatric principles in medicine, nursing, social work, psychology. It will alter qualitatively the curriculum of all schools, with orientation at least, and basic training often, in the principles of psychiatry. It will call for recognition of the psychological element in all walks of life, and in training for every phase of living and every profession.

The personnel problem will continue to be acute. It will be economically as well as socially bad to accept every kind of candidate for psychiatric postgraduate training. Selection of candidates will, therefore, become important. The Veterans Administration has just made a grant for research to discover the kind of doctor who is likely to make good in psychiatry. We hope to uncover some basic principles of selection, and apply these to doctors coming into the training program of the Neuropsychiatry Division. I predict it will not be long before improved methods of selection will be common in all graduate schools and will extend to undergraduate schools. Perhaps schools for social work are ahead of medical education in this regard.

The number of psychiatrists needed has been estimated as up to 20,000. That means 40,000 psychiatric social workers, and 20,000 clinical psychologists, according to the generally accepted ratio. It may be that this number can be reduced if greater use can be made of other personnel. The teamwork principle will extend the usefulness of all trained

individuals. This will modify the need somewhat. The reluctance of doctors to turn over therapeutic responsibility must be overcome, to make use of more people.

But this point must be made: Responsibility for life and death is a serious thing. A mistake may prolong an illness. Failure to diagnose and treat a condition in its early stages frequently means an early death or a life of torment for the sufferer. We believe that the solution of most psychiatric disorders is bound up in a combination of organic or physical plus psychological causes, requiring basic knowledge of the entire body-mind machine. Real understanding of complex conditions cannot be obtained without long years of study and considerable experience. College, four years of basic medicine, a general internship, and several years of post-graduate training go into the making of a psychiatrist.

Many people resent the Jehovah complex frequently found in doctors, particularly specialists. Are they the only ones who should treat an illness? There is a feeling in many people that they, too, should be allowed to share medical responsibility. There is some jealousy, some envy, and some hatred toward doctors, often mixed with the attitudes of some who would like to treat patients suffering from mental and personality disorders. Nurses, psychologists, and social workers sometimes fit poorly into a team, when teamwork is essential. The doctor is often at fault. He may be arbitrary, didactic, and have a Napoleonic complex—and sometimes he is a poor doctor.

It is necessary that all workers who have a common interest in mental disorders find common ground for working harmoniously together. There is room for all—each has an important place. I believe that we doctors would welcome the sharing of responsibility. All we ask is that the person who wants to take responsibility for an ill individual know what he is doing, come to his task well prepared, and be willing to pay the same price that doctors have to pay in terms of training, experience, and judgment. All professional people must pull together. We must do away with misunderstanding and jealousy and fit into the rôle in which we as individuals belong. I am sure there is no place where mental health is more needed than among professional

workers among mental patients. Let us apply mental hygiene to ourselves for the benefit of the patient.

9. With nineteen and a half million veterans in mind, I ask, what will keep these men and women well? Much less is known about prevention than about therapy. Pressure groups are powerful. Nuisance value is well known. No minority group can exert more pressure, or has a greater nuisance value, than those who are sick. We do not resent this. The sick and helpless have a special place in our hearts and much of life's satisfaction comes from aiding others. But we are prone to yield to pressure, exhaust ourselves with the emergency, and do little about preventing illness in those who are mentally healthy, and who are beginning life.

We neglect it also because we are indecisive—and we are indecisive because we are ignorant.

In the past, child-guidance clinics have constituted the major effort in prevention. These are making great contribution, but there are so few of them, I doubt if they affect the national picture at all.

Meeting the patient before he gets to the hospital—that is, treating a condition in a mental-hygiene clinic while it is still in its milder stages—is a well-accepted method of preventive psychiatry. Of course the patient is already sick when he comes. Mental-hygiene clinics also are most suitable for psychoneuroses, which should never be hospitalized in a mental hospital—and only when serious, in a general hospital. We are setting up such clinics and they will be good examples of teamwork in the best sense. The big increase in such clinics that we expect to come from grants in aid to states, and in medical institutions established under the Pepper-Priest Bill, about to become law,[1] will be a great addition to this form of preventive psychiatry. It is important that scientific checks be made on results in these clinics to see what they really accomplish. For our part, the success or failure of clinic work on veterans will be judged by the success or failure in reducing the number of hospital beds that have been estimated as needed on the basis of past experience, and in reducing the number of individuals getting compensation for illness.

[1] EDITOR'S NOTE: This bill has since been passed.

10. What is the relation of education to mental health? A good mental-hygiene environment is obviously beneficial to children, and efforts are being made to get this into all schools. Homes are breeding places either of happiness or of harm. Parents, especially mothers, teachers, employers, foremen, personnel workers, all in charge of other people, need special knowledge for handling their charges. In such cases, education in mental-health principles has to sift through an intermediary to reach the person who needs help and direction.

We know that information and insight are of value to a person after he becomes ill. Much of a psychiatrist's time is spent in what is called reëducation. What about giving all people, as part of their education, some personal knowledge of mental-health principles—adding psycho-physiology to physiology, adding mental hygiene to classes in hygiene? I believe this to be a useful field to work, but there are many who are pessimistic, who say that to understand the nature of fear does not remove a danger. But there are many of us who believe that understanding the nature of fear will reduce the fear, prevent it from being repressed, and often keep normal fear from changing into neurotic anxiety—all of which adds up to putting fear and anger into their proper places as problems to be solved.

It may be that one of the most fruitful elements in preventive psychiatry may be found in clinical psychology. Better methods of diagnosis to supplement experience, more understanding of personality make-up in normal and abnormal, and better methods for evaluating the results of therapeutic methods are all available from the field of clinical psychology. It is the solemn duty of all workers in the field of mental diseases to become better acquainted with the program of psychologists trained in clinical medicine. And it is the duty of psychologists to fit properly into the whole therapeutic team.

Prevention of mental diseases, the achievement of mental health for an entire nation, calls for the greatest possible effort, and a coördination of all possible sources of aid. We must somehow marshal the energy, the imagination, and the coöperative effort of all groups of society. Man does not

live by bread alone—he must have a good inheritance, freedom from disease, contentment, opportunity, freedom of expression, a degree of emotional satisfaction, some outlet for instinctive drives, a chance to grow and expand, some form of security, and a relationship with the Supreme Power of this universe.

Man does not live by bread alone—but he must have bread or he will die. Bread includes roofs, and dollars, and clothes, and some assurance that these will be available for minimum requirements.

Psychologically speaking, there must be a nice balance between freedom and security. Free enterprise supposedly gives freedom—totalitarianism supposedly gives security. There is some doubt whether either delivers sixteen ounces to the pound of its main product.

One of the greatest forces now operating in the country is the Social Security Act and the various provisions for unemployment compensation. These must be scrutinized carefully for the end results, and a period of years must ensue before it is determined just how far these provisions should go. Freedom from want must be balanced by stimulation to produce. The human being who, for one reason or another, does not work at something and produce something, will lose his zest for life and be a potential neurotic, a burden on himself and society. We must not be too sure about this—it may be that such a statement is true only in certain kinds of society.

The state of the country will determine much of the successes and frustrations of its citizens. This is a tremendous force in adding to or reducing the burden of living. Socio-economic laws are complex and baffling, but we must take all these things into consideration in national planning.

In closing, I would remind you that national planning for mental health is one of the great tasks that confront us. No plan can be formed until the problem is better understood. We must come to an understanding of the responsibilities of all the groups that must take part in its solution. We must evaluate present assets, and join together in utilizing them to the utmost. We must provide personnel who will do full-time work in the treatment of disease and the production of

mental health, and we must see that all others are well oriented and partially trained to help. Psychiatry must take its proper place in the medical world; teamwork will improve the care of patients and expand personnel to greater usefulness.

Leadership is required. I urge you as members of one of the great humanitarian groups in the world to take your place in the front ranks of those who are trying to make this world a better place to live in. I urge you and your officers, you as an organization, the National Conference of Social Work, to reach out into life and exert an influence proportionate to your strength and ideals. As social workers, trained in a professional discipline, you know more about the needs of human beings for the necessities of life than any other people in the world. Has this organization made its influence felt in the national housing crisis? Have you taken a stand for or against legislation bearing on the economic welfare of the people? Have the medical-social-work organizations had anything to say about the provision of the National Mental Health Act? Have your leaders approached the American Psychiatric Association and said: "Look here, we are interested in the mental health of the country, too. Are you planning to exert some leadership in this situation? Can't we help, too? Let's get together and push."

I wish to express again my great admiration for the professional social worker. No psychiatry worthy of the name can be carried on without your help.

FACTORS IN THE DEVELOPMENT OF STATE MENTAL-HEALTH PROGRAMS *

JAMES M. CUNNINGHAM, M.D.
Director, Bureau of Mental Hygiene, Connecticut State Department of Health, Hartford, Connecticut

THE planning entailed in initiating a new or expanding an existing state mental-health program calls for a knowledge of the distribution of the population, familiarity with the existing statutes, and a thorough understanding of the structural and functional organization of the state government and its administrative agencies. In certain instances enabling legislation may be necessary. The demand for and the character of psychiatric clinic service required may be directly or indirectly affected by statutes pertaining to the functions of other agencies.

No program can be planned or developed without reference to existing psychiatric services. Some of these services may have been provided by the state. Most of them have been developed in local communities under private auspices. A state program should not be planned to replace, duplicate, compete with, or conflict with satisfactory existing resources, but should provide for unmet needs and supplement existing services where these are inadequate.

Though considerable federal funds are made available to states, these are not likely to provide for all the possible needs. The limitations of available personnel will require selection as to the most urgent as well as the most practical services to be provided. In this respect, the degree to which the public is aware of particular needs is a factor that must be taken into consideration in the choices that must be made. With the variations that exist in the different states regarding those factors which create the frame of reference for a state mental-health program, it is doubtful whether a set

* Presented at the Seventy-third Annual Meeting of the National Conference of Social Work, Buffalo, New York, May 21, 1946.

pattern of organization or plan of services to be developed should be attempted.

Aside from building and maintaining institutions for the mentally ill and the mentally defective, there are a number of functions that may be included in a state mental-health program. The state may license and inspect private mental hospitals. It may make efforts to promote local psychiatric services. It may provide advisory and consultative opportunities. An educational program may be undertaken. The state may operate or subsidize psychiatric-clinic services.

The initial venture made by a state mental-health agency may be the promotion of local services by providing a professional person to work with local groups. Such an endeavor may be a duplication of the work of a state mental-hygiene society. The extent to which this can be successful depends very largely on the size of the local community and its ability to finance a clinical program. It depends also on the extent to which local communities large enough to develop their own services have already established them. In general, communities large enough to provide services through private voluntary sources have already done so. It seems apparent that any marked expansion of psychiatric clinic facilities must come through public funds.

Once a state mental-health program has been established and an organization developed to implement it, the professional personnel will find that they come to be used as consultants by other departments and agencies of the state government. This will happen whether provision is made for such activity in the original planning or not, particularly if the personnel secured are well qualified and capable. The demand for this kind of help grows as the mental-health program becomes established. This is especially true of those state agencies whose work is primarily with people. The health, welfare, and education departments, the vocational rehabilitation agencies, and the civil-service system are pertinent examples.

The development of any mental-health program requires public understanding if it is to be securely financed or properly used. From the very beginning, the program must be adequately interpreted to those groups in the state whose

work is in any way involved with the proposed new services. This requirement is necessary not only to assure a suitable reference of cases, but to prevent unnecessary defense reactions on the part of those organizations which may feel threatened by the new program.

This aspect of the educational work of any agency is actually a public-relations function. Many agencies, including mental-health agencies, are requested to give individual talks on specific subjects to small lay groups. No group of this sort can be educated in the complex factors involved in mental health in a single lecture. Multiplication of these individual talks to additional similar groups does not constitute an educational program. It may be, however, good public relations. Such talks often result in the reference of cases for clinical help if this is provided for in the program. For general educational purposes, the radio, newspapers, pamphlets, and movies offer a more effective and economical means of passing on information to large numbers of people.

Every psychiatric agency is asked by related organizations to assist them in their in-service training programs by giving a series of lectures to the staff members. Such a series of lectures may have value as far as initial orientation to a field is concerned. They should be accompanied or followed by case material, and this material should be presented for group discussion rather than as a didactic presentation. Often agencies make inappropriate requests both as to the subject matter desired and the methods by which it is to be presented.

The individual conference on specific case problems has educational values, and is often gratifying to workers. Over a period of time individual conferences with workers from other agencies may result in the acquisition of considerable knowledge. This method has the defect of being unplanned and unorganized so far as total educational effect is concerned. The staff conference of the psychiatric clinic serves an educational purpose as well as a method of integrating the work of the various members of a clinic team. Case-work supervision within the organization should be conceived of and conducted as an educational, not a therapeutic procedure.

The mental-health education of individuals in the preservation of their own health and that of their children is a matter

that is talked about a great deal, but very little is done about it. Most attempts in this direction have been rather bromidic. They are oriented around a rationalistic approach and take on the characteristic of preaching. There is much reluctance on the part of adults to accept various scientific findings in matters of health. This is due to emotional attitudes, which have their main sources in the experiences of childhood. To quote Lawrence Frank:

> "If health education were approached as a problem of epidemiology, it would be appropriate to start not primarily with scientific knowledge to be taught, but with the discovery and delineation of the ideas, beliefs, and feelings about human functioning, health, and illness which constitute the basic patterns of different groups in the population. This would mean studying the existing beliefs and living habits of different groups of people in each community to reveal their cultural traditions that vary according to ethnic, national backgrounds, and religious affiliations and other groupings. These traditional ideas and living habits constitute the social cultural environment in which people live, and offer the major obstacles and resistances to health education and medical care." [1]

The psychiatric clinic is a strategic agency for discovering what these feelings and attitudes are and what they mean to the individuals who hold them. With such data, an educational program might be undertaken, any techniques available being used for modifying these cultural patterns. Such methods might well be different from the conventional rationalistic approach. In any event they would be dictated by the dynamics of the emotional attitudes rather than by the scientific theories of the educator. Any or all of our modern methods of communication might be utilized.

The particular types of problem that are to be treated through clinical service determine the type of training and experience needed by the professional staff and also the ratio of the different types of professional service required. The incidence of different kinds of problem in the population is a determining factor in the amount of clinic time needed. As a result, a number of differences between the psychiatric-clinic services for adults and children have developed.

"Child-guidance clinic" is the title used to designate a psychiatric clinic for children whose professional staff includes

[1] See "Health Education," by Lawrence K. Frank. *American Journal of Public Health*, Vol. 36, pp. 357-66, April, 1946.

a psychiatrist, a psychologist, and psychiatric social workers. While the title has historical and affective values for those individuals whose work has been in such clinics, it does not in itself designate accurately the types of case seen, the character of the service rendered, or the professional personnel that gives the service. It is often confused by the public with guidance clinics, counseling services, psychoeducational clinics, and similar worth-while, but non-psychiatric agencies. If the term, "psychiatric clinic for children," is employed, much of the confusion is avoided and the question as to whether a child-guidance clinic without psychiatric services is worth while does not arise. If the clinic has no psychiatrist, it is not a psychiatric clinic and it can be evaluated in terms of the particular services that are rendered.

The typical child-guidance clinic has developed as an independent community agency associated with other agencies in the community chest. Seldom have communities under 200,000 population been able to develop and support such a clinic. Apparently the number of children referred from this population base will justify a full-time clinic. There are very few centers for training child psychiatrists. The economics involved makes the private practice of child psychiatry quite limited. Therefore, the small community that wishes to establish a part-time psychiatric clinic for children has great difficulty in securing competent personnel.

The metropolitan centers, on the other hand, are too large for a single community-type psychiatric clinic to serve all the children that need help. As a result psychiatric clinics have developed under various auspices—the school, the juvenile court, the social agency, and the pediatric departments of general hospitals. The advantages of the independent clinic are lost and sometimes the quality of the personnel and the functions of the clinic have been modified to meet the needs of the sponsoring agency rather than the needs of the children.

A state program of psychiatric-clinic service for children must solve the problem of how to distribute a high quality of service in an efficient and effective way to population groups too small to warrant or to be able to support a full-time service. The state has a large base of financial support and can employ competent personnel on a full-time basis.

Practically all children, except those requiring control of the child in residency, can be treated at a clinic, provided there is opportunity for psychotherapeutic interviews as often as once a week. Many cases do not require interviews as often as that and many more cases can be treated by case-work with the family, provided a diagnosis of the dynamics has been established, and provided the psychiatric social worker has real skill in modifying the attitudes of parents. Experience has shown that cases referred from a population of approximately fifty thousand will warrant a full day a week of clinic service.

A full-time clinic team can serve several communities at this frequency, although time must be allowed for recording, for conferences, and for office routine. To provide service to different communities on a regular weekly basis, the clinic team must travel. There is a feeling on the part of some child-guidance leaders that "traveling clinics" are no good, won't work, do only diagnostic work, and so on. Travel has nothing .to do with the quality of the service rendered. Travel represents only so much time lost and merely raises the cost of rendering the service, no matter what type of service is provided. Analysis of the failures of traveling clinics will show that the lack of high quality in the work is due to the lack of training in child psychiatry of the personnel used, the attempt to serve too large a population for the time available, and a time interval between clinics too long to permit psychotherapy for the cases that require it.

The term, "diagnostic clinic," is used in disapprobation and is often associated with the term, "traveling clinic," though some clinics that do not travel have been of the diagnostic category. The type of psychiatric examination given in such clinics is based on descriptive psychiatry. The result is usually a label substituted for a group of symptoms, with recommendations more or less suitable for a given category with little relevance to the specific needs of the patient.

The opposite of this extreme is complete absorption in the process that takes place in the therapeutic situation, to the exclusion of the etiological factors in the background and the current environmental stresses at play. Therapy begins with the initial contact, and diagnosis of the dynamics is never final, but is of necessity formulated most completely

on termination of contact. A brief-period study to evaluate the dynamics involved, conducted with therapeutic intent, requires much greater skill and experience than any other type of work with children. In situations involving decisions that affect the whole life of the child, such a study may be the most important therapeutic procedure that can be used.

Children are brought to clinics by adults, and this imposes certain problems in therapy and the coöperation of the parents. Symptoms that irritate adults are more likely to bring about reference to a clinic than those that do not. Consequently few cases are self-referred. Cases come from parents and from agencies that have some type of responsibility for the care and rearing of children. Since cases come from such a variety of sources in the community, the health department is probably the state agency best suited to operate such clinics. It is usually the only agency whose functions are not based on some segment of the population because of age, economic status, or type of human behavior. Clinics operated under such auspices are able to become integrated into the local community organizations and retain the values of the independent community clinic. The problems of securing personnel and the distribution of clinical service for children are best met by an operating program on the part of the state agency.

The types of adult psychiatric problem that are suitable and amenable to clinic treatment present certain factors that must be taken into consideration in planning a clinical service for adults. Attendance of the adult patient at a psychiatric clinic is dependent upon his voluntary coöperation. Patients who require commitment or hospitalization may be seen for emergency diagnosis. Psychopathic personalities are limited in their ability to coöperate in psychiatric treatment. The convulsive disorders, various psychoneurotic reactions, the so-called psychosomatic conditions, and certain types of alcoholic are the more common kinds of problem suitable to and coöperative in ambulatory treatment. These particular groups usually seek help for various somatic complaints from the general physician or the out-patient clinic of the general hospital. Many of them are admitted to the beds of the hospital for real or fancied somatic complaints. The laboratory facilities of the general hospital and the associated

medical specialists are often needed for differential diagnosis or auxiliary treatment.

Psychiatric-clinic service for adults requires more time from the psychiatrist than a service for children. There are enough psychiatric problems coming to a hundred-bed hospital to warrant a full-time psychiatrist on the staff. Patients seen in consultation on the general-medical wards may continue psychiatric treatment in the out-patient clinic and other patients may come directly to such a clinic. The general hospital would appear to be the natural setting for the development of psychiatric service for adults from the standpoint both of the patient's problems and of the requirements of good medical and psychiatric care.

The type of training and experience required of the professional staff is somewhat different for the treatment of adults as compared with children. A certain common background of training is required for dealing with both types of patient. Psychiatrists who have been trained in child psychiatry have usually had a minimum of two years previous residency experience with psychotics. It would be much better if at least one of these two years were spent in out-patient work. The treatment of psychoneurotic adults requires special training in psychotherapeutic techniques, over and above institutional experience with psychotics. The most common erroneous assumption is that experience with adult psychotics qualifies one to treat any kind of adult patient. Treatment of children and psychoneurotic adults requires psychotherapeutic skill, and seldom is this skill acquired through experience in the institutional treatment of psychotics. The opportunities for training in psychotherapy with adults are almost as limited as those for training in child psychiatry; consequently there are extremely few people qualified to do both.

If a state program for the treatment of adult problems is to center around the general hospital, the state agency may either subsidize the work in the hospital, or employ qualified personnel and secure permission from the hospital to conduct a clinic there. The key to successful psychiatric work in the general hospital is thorough integration with the other medical services. This can be accomplished only when the

psychiatric service is a part of the organization of the hospital. The method of subsidy with appropriate requirements of standards to be met appears to be the method of choice for the state agency to use in developing an adult program.

The United States Public Health Service has recently publicized the desirability of having "all-purpose clinics" for every 100,000 of the population. Like the terms, "traveling clinics" or "diagnostic clinics," "all-purpose clinic" does not indicate the nature of the purpose or the means by which it is to be achieved. Presumably it means a psychiatric clinic for the treatment of adults and children suffering from any kind of personality deviation or psychiatric disorder. Nothing is said about the quantity or quality of the professional staff necessary to do a good therapeutic job for a population of the size mentioned. The qualifications for "all-purpose clinics" recommended by the American Psychiatric Association omit any consideration of training and experience in child psychiatry.

The general objectives of the United States Public Health Service's mental-health program are highly desirable. There is obvious need for a large base of financial support, and there is also need for leadership to states which the service is in a strategic position to give. The need for research and the tremendous requirements for facilities for training personnel are adequately recognized in this program. No set pattern is proposed for either of these developments, but the development of clinical resources in the states is focused around a standardized plan. It is questionable whether it is desirable or feasible to attempt such standardization of approach without regard to the differences in the problem to be treated and without regard to the organization and development of various psychiatric resources in the different states.

A variety of factors enter into the planning, development, and operation of a state mental-health program. Such a program may have a number of functions. The clinical service has been given the greatest attention in this discussion because of the current demand for such service. The other functions are equally important and must also be developed if the program is to be well integrated.

SEPARATION ANXIETY

COMMANDER J. J. V. CAMMISA, M.C.
United States Navy
COMMANDER JAMES CLARK MOLONEY, M.C.(S)
United States Naval Reserve

THE war is over. Navy men are being separated from service. In some, this separation induces a state of acute anxiety. On Okinawa, tensions incident to facing civilian life were evident soon after V. J. Day. Four cases illustrative of this separation anxiety are presented below.

Case 1.—K.D., PhM3c, U.S.N.R., thirty-seven years of age, came for consultation because he had developed acute attacks of uneasiness: "My heart palpitates; I get breathless; I can't sleep at night; I can't eat; my chin and lips quiver. In brief, I don't want to go home to my wife and three children; I'm afraid of life."

K.D. had been raised under a régime of strict authoritarianism. His father was an abstemious man, a rigid Christian, and an inexorable disciplinarian. On the other hand, he could be benevolent when his commands were obeyed. He placed a premium on unquestioning obedience. Wilfulness was subject to punishment. It was to K.D.'s advantage to surrender his self-determinism, to conform to the father's wishes. This program gradually converted him to passive dependency. He had learned a technique for "getting along" with authority. Since his efforts at emancipation, his efforts at becoming an adult, were always attended by anxiety, it was more comfortable for him to submit.

This submissiveness, this inability to emancipate himself from the father, was demonstrable in his work record. He was injured on his first job. Alleged to have sustained a hernia from lifting, he had been operated on immediately. Despite this fact—and of significance for this report—his convalescent invalidism had lagged over a period of six months. From this time on, his industrial history was "spotty"—a few months here, a few months there, with interspersing periods of work on his father's farm. He narrated one incident that revealed his inward disdain of passivity: He had learned the barbering trade, but he would never become a professional barber because "barbers always agree with everything the customer says—this is sickening." That barbering was a culturally inferior undertaking for this man, who had graduated in the highest bracket of his high-school class, will not be commented upon.

In the more recent years of his pre-military life, he had become more steadily employed. In fact, he had been a salesman in a highly competitive business. The work had been arduous. Entertaining omni-

present feelings of inferiority, he had been constantly thrown in with a group of glib talkers. Comparing himself with them had caused him untold mental anguish. He had been hounded by thoughts of failure—of being unable to provide for his family. Defeatism had stalked his every step. Suffice it to say that, after the war, he did not wish to return to this harrowing existence. His defeatism was inseparable from his masochism. Of course, he had forgotten that many years ago his stern father had conditioned him toward "giving in to another."

Interestingly enough, many months before the cessation of hostilities, when to a man of his sterling integrity no discharge from the war had been in sight, K.D. had passionately pursued in word and fancy a desire to be at home with his wife and family. This passion had been a smoke screen that had covered his dependency. At least, it had been a manifestation of his ambivalence, for he had dreamed that he was free of his responsibilities; that, like Enoch Arden, he had lost his wife to another man; that upon returning home, he went unrecognized by his happy wife and family.

In the navy, K.D. had discovered an answer to all of his problems, a surcease from the demands of life. The government fed him, clothed him, protected him from extreme competitive situations, provided for his wife and children, and demanded very little from him in return. When he was obedient and self-effacing, the navy became his benevolent father, the kind father, the father who assumed his responsibilities. To leave the protection of the navy (the benevolent father) for civilian life would be like a child's braving the sinister darkness beyond the warm effulgence of the family home. K.D. "wore" the navy like a mantle of magic against the tribulations of a heartless world.

Case 2.—L.E., Slc, U.S.N.R., nineteen years of age, came for consultation because he was unable to sleep. He suffered from headache, tenseness about the mouth, nausea, and feelings of worthlessness.

Seeing the end of the war in sight, he desired to be transferred from his more or less stable outfit so that he would be available for the next operation. He confided to me that he had always entertained feelings of worthlessness, that he would never be able to do things well. In the navy, he had not succeeded when aggressiveness had been essential to the enterprise in question. He had failed in the V-5 and V-12 programs—failed with mediocre grades. He "washed out," but simultaneously realized that he could have done better. Some perverse impulse within him had defeated him. He no longer made plans for his future as an individual. In the past, when he had made such plans, the planning had always been attended by a strange sense of apprehension—a painful apprehension. Now he was content to be a drifter. He had never been a leader. He believed that aggressive people were never really liked. He wanted to be liked by everybody, so he went out of his way to be pleasant and agreeable to everybody.

L.E. had learned and believed that by his being born, by his coming to life, he had in some way ruined his mother's procreative apparatus. Because of his birth, his mother was unable to have any more children. His becoming a living being, capable of life, had been destructive to the mother. It is not entirely clear, however, why he became so neu-

rotically dependent. He clung to his mother's apron strings. He feared to leave home, and while away from home and in the company of others, he was harassed by feelings of inferiority and worthlessness.

During L.E.'s life, his mother had been subjected to nine abdominal operations. When she became sick, L.E. experienced morbid attacks of anxiety and depression. Our surmise would be that he not only feared the loss of the protective mother, but also, had she died from a pelvic operation, he would have held himself responsible for her death. He alone had damaged the birth canal; he had prevented the appearance of rival siblings.

L.E. had become a passive, dependent boy who feared to grapple with the adult problems of existence. The navy, while acting like a mother, afforded him the safety and comfort of a dependent child. At the same time, the navy allowed him to appear like an average adult, sparing him the ignominy attached by this culture to certain types of post-adolescent passivity. He feared to give this up for an unpredictable civilian existence.

Case 3.—J.S., HA2c, U.S.N.R., was ordered to see the psychiatrist because censors reported that his letters to his wife were repeatedly freighted with morbid content. The psychiatric interview unearthed the fact that he had participated, as the passive agent, in an almost overt relationship with a college professor. The professor, an older man, had been the aggressor. The affair had been going on for some three years prior to J.S.'s enlistment in the navy.

To mask his femininity, J.S. had also indulged in a promiscuous relationship with a woman older than himself. He had allowed his wife to learn of the existence of her feminine rival, but the affair with the professor had never emerged into the limelight. Though it worked havoc in his home, his half-secretive, half-exposed relationship with the older woman permitted J.S. the pose of a swashbuckling cavalier, a he-man who spiced his life by clandestine liaisons with extra-familial women.

It was his strange and oft repeated "negative" affirmation of his heterosexual prowess that first aroused the suspicions of the censors. In each letter to his wife, he begged her forgiveness for his transgressions—his transgressions with the older woman. He threw himself on her mercy; he averred that he wasn't fit to be the husband of such a sweet and lovely woman, he wasn't fit to be the father of her children. From the context of his letters, however, one could deduce that he pleaded too intensely, too often, and too persistently. His apologia masked a subtly exhibitionistic demonstration of phallic activity. By this strategy, he hoped to conceal from his wife the fact that she had married a person who, emotionally at least, was more feminine than masculine.

But even as he bragged in his negative way, he was at the same time ambivalent. His passivity was transparent, for almost constantly he complained of the abuse heaped upon him by the naval service. His masochism was enjoying a field day. He claimed that the medical officers ignored his complaints. They did not cure his eyes. He implied that this was due to complete neglect, despite the fact that he had worn glasses since childhood. They did nothing to strengthen his weak back, either. His complaints were almost without limit. He wanted

to get home immediately to his dear wife and family, to a civilian doctor who would pay some attention to his many illnesses. He was disconsolate; he could not tolerate the separation from his home. He alleged his health was so bad that he was useless to the navy; he was being detained in service for no good reason.

It would require no trained psychiatrist to see through these charges. J.S. was trying to make the doctor feel guilty so that, out of guilt feelings, the doctor would be moved to greater effort in his behalf. If he could make the doctor feel guilty, then he would be in a better position to control him, to move him about like a pawn on a chessboard. Further, he tried to make the doctor feel inefficient. This was a smoke bomb hurled by J.S. to prevent any understanding of his own inadequacy. He covered his own desperation, his sense of futility, by being the first one to hurl the word "failure" into the teeth of the other man.

Boiled down to its quintescence, with all screens removed, his behavior and complaints announced:

"I'm a poor, weak-backed fellow who needs support."

Suddenly, at the end of the war, frightened by the prospect of the resumption of his marriage, he became frank for the first time. He confessed, in a letter to his wife:

"You remember, darling, I was never a very potent man, so please don't expect too much of me when I get home."

Case 4.—S.W., SF2c, U.S.N.R., thirty-two years of age, sought out the psychiatrist because he feared what would happen to him after his release from service. He became explicit immediately: He was short of temper, and he was afraid that he would "fly off the handle" at his wife, and that she would divorce him. On one occasion, four years after his marriage, his wife had criticized him because he had stayed out late at night. He had been with some old friends, men he had not seen for a long time. He had felt justified in staying out. He had felt that his wife was curtailing his freedom. Going into a fit of rage, he had told her to get a divorce. She had taken him at his word, and the next morning she, in collusion with his own mother, had started divorce proceedings. It had taken him a month of earnest pleading to talk his wife out of her intentions. His fear of being abandoned had caused him to become moody and depressed.

During S.W.'s stay in the service, his neurotic nonconformism drove him into a few squabbles. These squabbles occurred almost invariably with a man of senior rank or rate. In almost every altercation, S.W. felt that the senior man was depriving him of something.

Peculiarly enough, the patient didn't worry about his civilian employment. Before enlistment, he had held down a job with a construction company, which frequently paid him two hundred dollars a week. Nor was he afraid of having trouble with his industrial superiors. As he explained it, he could always get another job. However, it was not so easy to get another woman who would possess his wife's stellar qualities.

It was learned that when S.W. was a little boy, he was very demanding. It was necessary for him to have his own way. By lusty screams, he bent his mother to his wishes. But these demands were used to cover up, to silence, his inner feelings of insecurity. Even as a child, he was so neurotic that it gave him a sense of unlimited power to be

able to press the mother into his service.[1] His omnipotence consisted of his ability to twirl his mother about his finger. Consequently, to preserve this delusion of power, he must never conform, he must never feel enslaved. His insecurity, no matter what its dynamic derivation, was manifested externally by neurotic nonconformity. To carry out successfully the salutary rôle of a neurotic nonconformist, it became encumbent upon him to have possession of a mother figure who would conform to his every wish, a figure who would do his bidding at all times. His feelings of confidence depended upon his being the puppeteer to a maternal stooge.

In his marriage, S.W. found himself trapped. To his astonishment, he found that he had to conform to his wife. He could not stay out as long as he wished. He had lost some of his freedom. And complications had set in. His own mother had turned against him. The wife, the mother substitute, had threatened him with divorce should he attempt any coercion. For his drama of successful living, for his sense of mastery, he needed a partner who would conform. He feared his inability to control his wife, but he feared even more the possibility of losing her. His demands in the first place had been for the purpose of determining the depths of the mother's love. He had to know whether his mother would continue to love him despite the utmost extremes of his "devilish" behavior.

Most of this conflict, and the source of the conflict, occupied an unconscious region of S.W.'s mind. Consciously, he had become aware of an inexplicable anxiety. With release from the service, he would find himself reintroduced to the past marital state of conflict. In our opinion, it is not often that a neurotic nonconformist desires to remain in service. The authoritarian aspect of the service is too much for him. But at times, even a neurotic nonconformist will prefer the hide-away potentialities of the service to the painful features of certain disagreeable and unavoidable civilian circumstances.

At the end of the war, some of our fellow officers whimsically yearned to visit Japan or Korea. They said that they would not mind being stationed for awhile in Shanghai, Hongkong, Singapore, or Ceylon. Or they preferred the long way home, via the Indian Ocean, through the Red Sea, the Suez Canal, the Mediterranean, and hence across the Atlantic to the "good ole U.S.A." These same men, during the war, when it seemed as if they were being detained in service by invisible chains of patriotism, had vociferously averred that they desired to get back home at the first opportunity; they wanted to be with their families; they wanted to resume the practice of medicine under competitive conditions; they ranted against socialized medicine. At times, it is difficult to determine whether these men delude themselves, their families, or both.

[1] See "Escape," by James Clark Moloney. *Psychiatry*, Vol. 8, pp. 9–11, February, 1945.

Often the man in service possesses considerable insight into the nature of his separation anxiety. One medical officer stated that he dreaded being released from service. He frankly admitted that the service in war time afforded him a patriotic excuse for not assuming his family obligations. A hospital-corps officer knew that he had shipped over in 1939 because he did not relish being mixed up with the competitive structures of civilian living.

If we were speaking exclusively to an audience of psychoanalysts, we could produce other bits of evidence indicating "marriage" to the service. There are men who, at the termination of the war, have "accidentally" burned or mislaid pictures of their wives or families.

Perhaps most men, on the eve of their separation from naval service, will entertain some apprehensions about the future. In many, the alarm is modified by the realization that they made successful adjustments in the past, and that what was accomplished before can be accomplished again. In some cases, there will be special etiological factors behind the separation anxiety. The man who is filled with repressed hatred for the stay-at-home will be uneasy in civilian life. The man who has guilt feelings because he dared to become a military man may feel tense when surrounded by meeker civilian confrères.

We do not intend to present a case-by-case description of these special orders. We submit the proposition that the most intense instances of separation anxiety will develop in those individuals who were predisposed toward making a neurotic tie-up with the service. Being bound to a stable pillar is no innovation for this type of man. It is not a spontaneous phenomenon occurring in a heretofore psychologically healthy adult. For this individual, the service becomes a substitute for a parent, quite often for the mother. To him, the world outside fosters the same hostile uncertainties that lurked in those earlier glooms that were pushed back by the periphery of his childhood home. In this immature individual, the intensity of his separation anxiety will be directly proportional to the intensity of his neurotic dependency on the service.

The severity of the separation anxiety will determine the

future disposition and vicissitudes of the patient. The patient who is temporarily slowed up by the "barnacles" of adolescence will eventually navigate his troubled waters. He will steer his way clear of his tension state. Gradually, he will make an adult integration with reality, with civilian life.

Others will met the situation by "shipping over." These people accepted by the navy for continued duty should be subjected to penetrating psychiatric examination. This examination would be for the purpose of determining whether the man shipped over because he genuinely desired to make a career of the navy, or because he feared the importunities of civilian life. In the latter case, during the man's peace-time "hitch," he should be given adequate psychiatric insight into the nature of his dependency as well as competent training in some skill that would afford him the confidence necessary for living as a civilian.

At the termination of the war, there will be a large and socially important group of passive dependents who, because of undesirable characteristics, will be more or less forcibly, though honorably, ejected from the navy. This group were not made neurotic by the navy. Before their period of service, they were dependent upon some sustaining host. The naval service did not cure them, did not make men of them. And after their discharge, they will seek out another host. Making concrete some vague "illness" or "injury" sustained in service, they will become parasites on the Veterans Administration. Scientifically, in the interest of calling things by their right names, these passive dependents are not war neurotics, yet many will attempt to wear this cloak of honor to make legitimate and to glorify their claims. Their fundamental neurosis was not aggravated by the service. Many of them did not experience the hazards of combat duty. But in cases where there is clear evidence that an illness or disability existed prior to enlistment, "aggravation" will become the open sesame to veteran's compensation. To a person of this passive, dependent type, compensation is the poison that will gradually disintegrate his last remaining shreds of integrity.

These cases will constitute the cultural casualties of western civilization. Had there been no intermediate naval host, most

of these men would have gravitated to another type of dependency. They would have swollen the ranks of such organizations as the W.P.A. Incapable of adult aggressiveness, they feel ashamed of their continued infantilism. No wonder that they try to mask their shame with grandiose pretensions.

Because the culture made these men neurotic, the culture is obligated either to cure or to care for them. Regardless of laws to the contrary, it is inconceivable that these character neurotics should become the moral responsibility of either the navy or the Veterans Administration. Their incessant and unquenchable demands will become confused with the proper expectations of the neurotic who was actually made sick by the war. Undetected in their masquerade as war casualties, they will tend to detract from the claims of those who are rightfully entitled to compensation or post-war aid. Banding together into powerful service organizations, they will become politically influential. In attempting to satiate the insatiable demands of their infantilism, they will undermine the very foundations of our democratic institutions.

CONCLUSION

In considering separation anxiety, attention should be directed toward the factor of passive dependency. Because it has been inadequately studied, passive dependency is too frequently assumed to be service-induced. The termination "aggravated by conditions of service" is a legal phrase that too often gives no indication of the actual psychiatric condition. Aggravation often springs from an intrinsic derangement and is an indication of an internal lack of capacity for average adjustment. The neurotic symptoms that are "aggravated" by service are not static; they subside in a more plastic milieu. But whether active or inactive, symptoms are not an accurate measure of the actual or latent depths of the neurotic process.

The passive dependent becomes the responsibility of the Veterans Administration only in so far as the administration is morally obligated to return him to some civilian psychiatric facility in the community in which the disability originated.

THERAPY: A FEELING AND DOING PROCESS *

JOHN EISELE DAVIS, Sc.D.

Chief, Corrective Physical Rehabilitation, Veterans Administration, Washington, D. C.

I WANT to discuss briefly therapy as a feeling and doing process, and particularly these related aspects: (1) medicine by authority; (2) the techniques of the physiotherapist; and (3) some of the ways in which we can enrich our knowledge and help ourselves to fit more effectively into the areas of usefulness that have been discovered and explored by this profession.

It is generally agreed that one's attitude toward one's work provides the significant "X" factor that may make one useful or useless. In the development of medical adjuvants, such as physiotherapy, occupational therapy, and recreational therapy, it seems quite natural to stress treatment by authority. The doctor prescribes the treatment; the nurse or attendant administers the treatment. Even to-day, one hears the term "subjected to treatment." White gowns and other trappings of the medical profession quite naturally attract attention to the giver rather than to the receiver of treatment. There is a strong social pressure "to take your medicine—to coöperate with the medical authorities." The annals of medicine are replete with crusades against illness in which the perils of disease have been overcome by the strong and persistent hand of medicine. Specialization has become so necessarily regimented that its techniques leave the patient little room or means whereby his own idiosyncracies and peculiarities, which have made up his coveted individual pattern, may find expression. In mental hospitals of past days, this outmoded concept of treatment was evident: "We have the patient and we have the treatment and

* Presented at the Commencement Exercises of the Physiotherapy Class, Columbia University, New York City, August 10, 1945.

he will take it or else." The dark shadows of this idea are still lurking behind us.

I am not here to-day to question the value of a positive and confident medical approach. Medicine, knowing where it is going, should keep its head high, as does the warrior skilled in disciplined aggression, fighting for a worthy goal. A great power of medicine, however, is its humanism; and the point I am trying to make to-day is that this humanism, so important as a part of effective medicine, includes far more than a kindly and sympathetic approach; more than a sensitiveness to æsthetic values and the enrichment of culture. There is another factor without which medicine may become a weakened formality. It is the feeling upon the part of the patient that he himself is the primary actor in his treatment.

This is evident in the commonplace axiom that the finest thing a person can do for one less fortunate is to "help him to help himself." We must help the patient to a sane realization that he is ill, imbue him with the desire to get well, and teach him not only what we are trying to do for him, but the various steps in his recovery, so that he may parallel these stages with the necessary motivation and spirit. This is a philosophy of medicine that of course goes back to the concept of the psyche and the soma as inseparable partners in illness and health.

In modern parlance, this new emphasis is termed "insight therapy." And I know of no better application of it than is exemplified by the modernized techniques of the Army Air Force Reconditioning Service under Colonel Howard Rusk, who has developed this approach into a dynamic therapeutic system. The young soldiers coming from this war want to know what it is all about. I have found from my own experience that they will ask for a greater variety of recreational activities and are more independent in their likes and dislikes than were the veterans of World War I. In a new world of constant change, they ask questions. They even ask questions about medicine. They want to know the score. They are not impressed by white gowns and all the conventional pomp of technological gadgets. In other words, in the realistic and commercial world of to-day, we have to "sell" our treatment to the patient.

This is not as superficial as it may seem. The patient is not buying a commodity like a hat or a pair of shoes, or an insurance policy that will pay his wife upon his death. He is buying something in an ever-present reality—something that has to do with his attitudes, his feeling toward himself and toward others—something that has to do with that fine balance of mental equilibrium which produces a positive purpose and a pleasing integration. He is buying something well worth while.

The patient not only is buying this psychological medicine, but he is making an investment in the personality of the therapist. You in the profession of physical medicine become an integral part of the treatment. How important, therefore, it is that, in addition to a knowledge of your specialty, you cultivate within yourself what Adolf Meyer has styled, "the infectious personality." Thus our philosophy of treatment is extended, and we add "that we not only have the patient, but the patient has us; and we, the patient, and all the factors and influences of yesterday, to-day, and to-morrow enter into and become powerful contributors to this new concept of therapeutic usefulness." In the last analysis, the validity and status of medicine is established by the patient.

To sum up, let us appreciate the importance of insight therapy in creating a strong therapeutic liaison between the therapist and the patient, who thus becomes not only the receiver of action, but the willing, understanding, and coöperative doer. Let this be our key to open the door out of the halls of learning into an arena of challenging usefulness.

Let me say a few words about the techniques of the physiotherapist, and here again I must refer to my own experience and confess to the limitations that such a viewpoint involves. It has always been my belief—and it is the conviction of many others with whom I associate—that the psychotherapist who knows activities and bases activity upon a "doing process" is more effective than the individual who relies entirely upon a talking process. A conjunction of the two is most effective. I would suggest, therefore, that we examine the possibilities of relating wholesome mental states to physical activities. In this area you will find room for interesting speculation as well as most practical work.

I hope that I am not getting too far from base when I suggest that you examine some of the modern concepts of psychoanalysis, particularly the psychoanalytical concepts of work and play—such as have been developed by Karl Menninger in his book, *Love Against Hate*. In a world characterized by peaks and valleys of aggression and submission, it is interesting to study the implications of work and play as types of these relationships. It is of course evident that whereas physical modalities may be prescribed for certain physical conditions, the psychological implications are none-the-less fundamental.

We are still too prone to accept our teaching under the compulsion of authority and let it go at that. Norman Thomas once said: "It is all right for the teacher to assert that 'I say so and so,' but it is not all right for the teacher to affirm that 'God and I say so and so.'"

I am reminded of a recent experience in this city. A woman, undoubtedly mentally ill, entered quite hurriedly into a bus on which I was riding, sat down, and flatly refused to pay her fare. The bus was almost filled and street traffic was heavily congested. The driver had never run into anything like this before and did not know what to do. It was an extremely interesting situation for me. I could not help thinking that right here in miniature was a picture of the mentally sick individual in his impact with society. I naturally wondered what would happen.

The driver began to argue with the lady, who persisted in her refusal to pay her fare. The more he argued, the more complicated the situation became and the further away from solution. Finally, he threw up his hands, exclaiming: "I absolutely refuse to budge! I will not start this bus until you pay your fare!" The woman was obdurate, refusing to be moved one way or another.

Finally a timid old man rose from the back of the bus, walked quietly forward, and deposited the fare in the box. The bus driver then proceeded on his way.

This is, of course, what the public has been doing all along for the mentally ill—paying their way and letting it go at that. This is a tendency not only of the public, but of professions toward professions and toward other people. So

many medical procedures have grown uncritically; some one just did it that way a long time ago.

As to another important development in our techniques, we must decide what are useful and what are useless activities. This will bring us to this important problem in physiotherapy: What are therapeutic or purposeful activities and what are diversional—and thereby, by implication—non-purposeful activities?

There are those who speak of functional activities as alone being therapeutic. They go on to explain, for example, that if a muscle that has to do with the extension of the arm is paralyzed, movements involving flexion and extension would be functional because they would serve to activate the muscle that is sick and, therefore, in need of treatment. By the same token, any exercise that would move that segment in any other direction would not be therapeutic since it would not involve the parts that are paralyzed. This in miniature presents an idea that has assumed such wide proportions as to throw a cloud over diversional activities, leaving them in a light that, if it does not deny their place, nevertheless does relegate them to an inferior position in therapy.

When we analyze the situation, we find that moving the muscle up and down the same way over and over again, while it activates the parts that are affected, becomes tiresome and even boresome, and after a while the patient does not want to do it any more. On the other hand, if we alternate these movements with those involving other muscles which are not affected, we can present a balanced exercise sufficiently motivated to make it in some degree pleasing and to insure its continuance.

If this is the case, it would appear very difficult to term activities that produce movement in the definitely affected parts as purely functional and therapeutic and those of non-affected parts as diversional and therefore non-therapeutic. Both should have the validity of a medical status.

The modern techniques of the physiotherapist will lay great stress on psychological values. It is very natural for the therapist to accept the physical aspects of physiotherapy as predominant. Upon a recent trip covering various mental hospitals in this part of the country, I was very much

impressed by the fact that in some cases physiotherapists had given sedative pack treatments to hyperactive patients, making them quiet and markedly relaxed. In other clinics patients of the same type, receiving identical treatment, were tense and in some cases markedly disturbed. Noting this in a great many hospitals, I was led to the conclusion that some therapists were cleverer than others in preparing their patients psychologically for this treatment. This experience also confirmed an opinion I have long held on the importance of giving every therapist a personality test to determine the effect of his personality upon the patient. A mastery of techniques is not enough.

Along with this psychological material, the therapist should observe and try to create interest in people. The simple process of trying to find what people like and talking to them about it is not devoid of valuable therapeutic implications. It is equally important to discover motivation in people and to use this as psychotherapeutic material. We must realize that it is not only necessary to stress what the patient knows about his treatment, but also how he feels about it.

It is also necessary to be able to make up our minds just what the central problem is. It is natural for the doctor to feel that it is medical, for the psychiatrist to feel that it is mental, for the social worker to feel that it is social, and so on. In close contact with the severely ill, you will discover that there are a multiplicity of factors involved, many apparently outside the realm of conventional medicine.

Dr. George B. Deaver told me of a patient of his—a transverse myelitis case completely paralyzed in the lower part of the body. As you know, this is an extremely serious ailment which calls for an enormous amount of will power combined with specialized exercise if the patient is to learn to walk with the aid of crutches. This young man said that he simply could never walk again—that he was done for; and with all the methods at his disposal, this capable orthopedist was unable to arouse the necessary incentive in him.

Unwilling to try to walk with crutches, the patient secured a stroller, and by this means pushed himself around the streets of New York. One day, to the doctor's great surprise, he declared that he thought he could learn to walk

with crutches and was willing to attempt the long, tedious steps of reëducation that were necessary. Highly motivated, he made a most superhuman effort to get back on his feet. Finally, after months of reëducation, he was able to walk on crutches. The first thing he did after acquiring the ability to walk was to get married. It was learned afterwards that he had fallen in love, and the desire to get married had provided the motivation for the long period of reëducation necessary for his recovery.

In the organization of techniques, the mental and physical implications of skillful development should be considered. A dementia-præcox patient comes to mind. Constantly beset by harassing hallucinations, this patient seemed unable to concentrate on constructive activities. One day while walking past the golf course and seeing others play, he remarked casually, "I used to play golf." This remark was noted by the therapist, who got the patient clubs and helped him get started again in this activity.

The therapeutic problem here was very interesting. The patient had a good foundation in skills. He practiced faithfully and was able to show some improvement. He insisted upon playing by himself, however, since he claimed that his opponents would influence his ball. Whenever he made a good shot, he seemed to feel satisfaction—would smile and at times talk coherently about it. Whenever he made a poor showing, however, he would stop and talk to imaginary voices who were upsetting his game. In spite of this, he improved and was able to hold his own against the better grade of players.

He became the victim of two strong motivating forces. One was the sense of satisfaction that he gained by his improvement in skill, and this was of course a normalizing influence. Opposed to this was the desire to pay attention to those disturbing voices, to talk back to them and to organize his aggression against the imaginary forces. As a result of daily playing, however, there was aroused a very strong desire to win and to secure the recognition that comes to the winner. He soon found that in order to do this he had to pay more attention to the ball and less attention to these phantasy creations.

At the end of the second year of playing, he won the hospital championship and this seemed to stabilize him considerably as he was given public recognition in the form of a medal for the championship. He began to enjoy playing with others. From this time on, he seemed able to throw these voices further back until they became hardly a discernible part of his behavior. This patient has been discharged as cured and to-day is making a very satisfactory adjustment in a responsible position.

As physiotherapists, you will have many opportunities to observe this integrating force of skill in the promotion not only of physical health, but also of mental happiness. There is a deep psychic satisfaction in being able to control our bodies through fine motor manipulation. The relationship of this control to the control of our environment provides an additional area of hygienic application. Attitudes of confidence and disciplined aggression are rich in these experiences and are much more easily produced in this way than through the conventional methods of a talking psychotherapy.

We have been speaking of techniques in their application to the patient. A word about ourselves would seem in order. We must keep alert to our own potentials as well as the developments of our profession. This country of "the American way" seems to include a distinctive formula for doing everything at one and at the same time. While we have been taught "to make the most of our best for the sake of others," we have not learned how to organize our lives in the most effective way to do this. In addition, we have a difficult person to live with and work with. Charles Lamb reminds us, "If there is a regal tyrant, it is the sick man. . . . He is ever plotting how to do some good to himself—studying little strategems and artificial alleviations. . . . He is never quite satisfied."

It is not easy to outline one's day in a sensible fashion so as to enable one to direct energy into the most effective channels. How are we to get along with ourselves? In the first place, I am sure that you have a genuine interest and love for and in your profession. If we do not have this, we are sunk. The next step is to organize this interest so that it may brighten our efforts. And the step after that is our

physical planning, and all I can say about this is that we should try to do one thing at a time. The difference between successful and unsuccessful people I have seen has often been the difference between a person who could plan his day and a person who trimmed his sail to meet every changing wind. We can afford to be neither perfectionists nor rationalizers. Some one has said that the perfectionist never gets anything wrong and the rationalizer never gets anything right. We must learn to conserve our energy for its most fruitful application and to get some order out of the daily chaos of life. Harry Emerson Fosdick writes this little ditty:

> "There was an old sailor my grandfather knew
> Who had so many things which he wanted to do,
> That whenever he thought it was time to begin,
> He couldn't because of the state he was in."

We are entering into a world in which the individual is coming to claim more prestige and attention than ever before.

Some psychologists explain this as the resurgence from a life-and-death-struggle of individuality, attacked by the gods of war. This stress upon individuality, in my opinion, provides the most productive point for our therapeutic attack. The patient will cling to this pattern of individuality as a sinking sailor grasps for the smallest piece of floating débris. We must, therefore, know more about people, their wants and needs, and we must know more about them as people. As Dr. Alan Gregg affirms: "Patients would rather be understood than X-rayed. It is necessary to X-ray them, too, but this should be done with the understanding that they are above all—'people.'"

Finally, we must clear the therapeutic atmosphere of the stigma that still darkens many diseases, both physical and mental, with a cloud that lowers our social and economic perspective. We cannot help the patient if he feels that he is a sinner, or that society does not want him, or that we are treating him from the high and lonely position of duty, or are using authority rather than humanism as our guiding star.

We are going along together on an interesting road. Let us not pay more attention to the landscape than to the direction, nor to the stopping-off places than to the final objective.

THE "QUESTION-BOX" METHOD OF GROUP PSYCHOTHERAPY

LIEUTENANT COLONEL JACOB H. FRIEDMAN, M.C.

AND

CAPTAIN LEWIS W. GERHART, M.C.

Neuropsychiatric Service, Bruns General Hospital, Santa Fe, New Mexico

GROUP psychotherapy has been employed by psychiatrists prior to the present conflict with good results. Among the workers in this field may be mentioned Wender,[1], Burrow,[2] Schilder,[3] and Bender.[4] The army also has recognized the value of group psychotherapy and has issued a training bulletin[5] to that effect. This bulletin concludes:

> "The favorable response of patients to comparatively brief treatment in groups, warrants widespread adoption of this method of therapy. When patients are treated promptly, a majority can be salvaged for useful military service. It should be remembered that group psychotherapy is just one small part of the total treatment program. Those who cannot be salvaged will return to civilian life with the advantage of having been properly oriented about this disorder."

Group psychotherapy was introduced to open-ward neuropsychiatric patients at the Bruns General Hospital by formal lectures and discussions of individual cases. There were about thirty neuropsychiatric open-ward patients at each session. These patients, presenting varying neuropsychiatric problems, came from all walks of life and from different geographical localities. The patients were too few to be grouped into units of similar background and problems.

1 See "Group Psychotherapy: A Study of Its Application," by Louis Wender. *Psychiatric Quarterly*, Vol. 14, pp. 708–18, October, 1940.

2 See "The Psychoanalyst and the Community," by Trigant Burrow. *Journal of the American Medical Association*, Vol. 62, pp. 876–78, June 13, 1914.

3 See "Results and Problems of Group Psychotherapy in Severe Neurosis," by Paul D. Schilder. MENTAL HYGIENE, Vol. 23, pp. 87–98, January, 1939.

4 See "Group Activities in Children's Wards as Methods of Psychotherapy," by Lauretta Bender. *American Journal of Psychiatry*, Vol. 93, pp. 1151–73, March, 1937.

5 T. B. Med. 103, W. D. Tech. Bull., 10 October, 1944.

It was repeatedly noted that a large number of patients paid no attention to the formal lectures and that very few would take part in the discussions, although the leaders and moderators of the group were considered interesting speakers and enthusiastic about this type of therapy.

After careful reflection, it was decided that a common denominator was lacking for the customary type of group psychotherapy in this diversified aggregation of patients. These patients, however, had a number of things in common—all were army personnel; all were classified as neuropsychiatric patients; all slept on the same ward; all ate the same type of food; all took part in the same reconditioning program; and all had the same ward officer. Therefore, these factors, common to all, established a mutual bond among all the patients.

It was, then, felt that this mutual bond should be utilized as a common denominator for group psychotherapy in order to get the patients interested and enthusiastic about the treatment. This common denominator could further be attained by having the neuropsychiatric topics and case presentations for discussion chosen by the patients themselves. This was accomplished by what we term the "question-box method."

A cardboard box was installed on the ward with the notation "Question Box." Prior to each talk, patients who are new to the group are told the objects and aims of group psychotherapy, and are invited to place anonymous written questions in the box, pertaining to their own cases or to any neuropsychiatric problem in which they are interested.

The group therapeutic sessions are held at the same scheduled hour three times weekly. Newly admitted patients, as well as older resident patients, participate. The moderator is the ward officer, the assistant chief, or the chief of the neuropsychiatric service. The questions are answered in order, as they are taken out of the box. The moderator has no previous knowledge as to what question will be asked, and, therefore, impromptu answers are given. Each session lasts approximately one hour. All questions in the box are answered at each meeting.

After a query is answered, volunteers from the group are

asked for their comments. Frequently, there is a repetition of questions, and then the moderator asks one of the older resident patients to reply.

The leader usually attempts to respond by means of case illustration. As a rule, the case chosen for discussion is that of one of the patients present. Often a patient will volunteer his own case or the cases of fellow patients in the group. Thus, each question brings forth many responses. At times, a vote is taken as to the advisability of a certain disposition.

At a few sessions, no questions have been placed in the box. If this occurs, the leader asks the group what subject or subjects they would like to discuss. The subject chosen is then discussed, with patients voluntarily presenting case material. The entire procedure is informal. Patients who have been shy very soon join in the group activity. In this manner we have been able, more successfully, to make the patients realize that they are members of a group of men who have similar problems and difficulties. The patient is able to identify himself with the group, having a realization that the group is friendly. Furthermore, through the question-box method, the patient can ask questions without fear of punishment or ridicule, as the queries are anonymous. As a rule, patients readily discuss other patients' problems, but are reluctant, at first, to discuss problems related to their own conditions. By repeated similar questions and discussions, many patients apparently accept their neurotic symptoms or behavior problems as an escape from an unbearable reality situation. The success of this method can also be judged by the informal discussion of small gatherings immediately following the group-therapy hour.

The function of group therapy in the therapeutic endeavor makes use of intellectualization, patient-to-patient transference, catharsis, and group interaction, as pointed out by Wender.[1] The question-box method in no way interferes with the dynamics of group psychotherapy. Our method also shows the moderator or leader as a "just father," who treats all his patients (children) equally, and this helps overcome the problem of sibling rivalry. Furthermore, by the ques-

[1] *Op. cit.*

tion-box method, the questions can be negativistic or critical and can be asked with the intent of confusing the leader. In this way, aggression is channeled off into harmless activity. We feel that this procedure facilitates the production of aggression and hostility, allowing emotional abreaction to take place. This is never permitted to attain such a degree of intensity that the group gets out of control.

We realize that in group psychotherapy others have incidentally employed a question-and-answer method in conjunction with formal lectures and case presentations. We, however, use the question-box method exclusively, and the case discussions as well as the informal talks are based entirely on the questions. We have found this technique more advisable than the customary one for a heterogeneous group of neuropsychiatric patients. The acting neuropsychiatric consultant for the Eighth Service Command, after witnessing the method, approved of the procedure and characterized it as, "a somewhat unique and original program of group therapy."

All the questions submitted by the patients over a six-month period were reviewed with the intent to determine what information pertaining to neuropsychiatric problems was most desired by the patients. Analysis revealed that these questions could be grouped into several categories. Examples are given verbatim.

Category I. Questions on the Relationship of Functional Diseases to Somatic Symptoms.—In this group we have included all questions in which the patients could not understand how bodily pains, aches, discomfort, and all types of abnormal sensations were present in the absence of organic disease. Questions of this type represented 24 per cent of the total. The questions below are examples of this group:

> "Seems as though I lost ambition for everything, don't care to do anything at anytime. Could nerves be responsible?"
>
> "Do you think nervousness is the main reason for a man to have a difficult time sleeping at night?"
>
> "Can nervousness cause blindness for short periods of time. How?"
>
> "What makes a man's hands sweat when he is doing nothing?"
>
> "Why does a person with a smashed finger on one hand also get pains on the other hand fingers? Why do pains change when there is nothing wrong with the other hand?"

The most difficult aspect of group psychotherapy has to do with this category. The relationship of psyche and soma through the medium of the autonomic nervous system must be repeatedly explained to the patients. Examples to illustrate the mechanisms are readily obtained from the patients' own cases. Volunteers are frequently obtained from the more educated patients to discuss the questions, and these patients are thus enabled to display their narcissism as well as to win the approval of the leader (good father). These patients attempt to explain the mechanisms involved to the less educated or the more emotionally resistive patients.

Category II. Questions Pertaining to Psychosomatic Problems.—Fourteen per cent of the questions fell in this group. These questions, as shown by their wording, were apparently asked by the better educated members. As a rule, this type of question did not directly apply to any one in the group. The formulation of the questions led us to believe that the patients had voluntarily been reading literature on psychiatric subjects. Examples:

> "Is there any relation between neurosis on one hand and blood pressure temperature and pulse on the other hand?"
>
> "How can psychologic conflicts produce structural alterations in the tissues?"
>
> "Please explain the cause and effect of paraxysmal tachycardia."
>
> "What are the anthropologic pecularities in ulcer patients?"
>
> "After an amputation of all five toes on the right foot a soldier complained of his toes hurting him in cold weather, he also complained of cold toes. How could this be when there were no toes present?"
>
> "Please explain migraine headaches. (1) Cause (2) Symptoms (3) Cure."

These questions were always answered, although at times they did not pertain to any of the patients in the group. Too much discussion was not encouraged if the question involved did not apply to any of the patients' cases.

Category III. General Medical Questions.—This category comprised 25 per cent of the total, representing the largest number of questions. At first impression, it might appear irrelevant to answer some of them, as there seemed to be no relation to neuropsychiatry. However, it was noted that a general medical question related to some information an individual in the group desired in order to allay anxiety. Furthermore, a general medical question often referred

directly to a problem which had a bearing on the patient's neuropsychiatric condition. Examples of this group are the following:

"Can syphillis be cured, how and how long?"

"What is cerebral thrombosis and will it improve with time or gradually become worse?"

"What is the safe time in a month that you can't make a woman pregnant?"

"Is TB curable and what causes TB? Is it possible to contract TB from a person with inactive TB?"

"The world seems to be vitamin conscious to-day. Do the various vitamins B concentrate advertised to help nervousness do any good in that direction or is it a beautiful job of salesmanship?"

"What is Beurger's disease? Does excessive smoking accentuate it?"

These questions would usually provoke considerable discussion. Only one patient's case would be involved in one of the questions. Those patients who were not directly involved would readily discuss the problem, as there was no emotional resistance. However, the moderator, knowing the individual cases, was able to shift the trend of thought toward the problems of the most voluble ones. One general medical question, therefore, would invoke discussion of other problems, and a large number of patients would be benefited.

Category IV. Administrative Questions.—This group comprised 14 per cent of the total. It included ward administrative problems and war-department policy in relation to duty status or discharge. These questions, as a rule, did not invoke much discussion, except when they involved discharge from the military service or furloughs. The value of this type of discussion was to dissipate constructively hostile grievances and aggressions of a number of soldiers. It also helped to clear many misconceptions. Examples:

"Is it possible to receive a pension if the man was not put in line of duty? About how much would this be a month?"

"Now that the war is over and they are going to discharge so many men, why are most of us going back to duty?"

"Is it your opinion that a soldier who is suffering from a mild case of psychoneurosis would be better off in civilian life than he would be in the army?"

"Can an overseas patient be discharged from the ward on CDD for physical injuries or does he first have to go to a convalescent hospital?"

"Can we use our bed lights from 2100 to 2200?"

"Please explain reason or reasons for sending a man back to duty at a post where he was unsuccessfully treated over a period of months."

Category V. Questions Concerning the Dynamics of Functional Illness.—This group of questions represented only 8 per cent of the total. They gave rise to considerable discussion. The leader always exemplified the explanation by case presentation. Examples:

"Can one mind pull from another when one is mean and the other is good?"

"What is the difference between Psychosis and Neurosis?"

"Please explain the importance of relative affection for each parent in diagnosis of functional neurosis?"

"Why would a fellow prefer an older woman than one his own age?"

"How long does a dream usually last and what is the reason for a dream?"

"What makes a person think something is wrong with them when there actually isn't anything wrong?"

The discussion of the topics in this category really served as part of a formal didactic lecture. However, the leader always employed case presentations for illustration with the participation of the patients.

Category VI. Questions Pertaining to Diagnosis and Therapeusis.—This group represented 15 per cent of the total. These questions invoked the most enthusiasm and interest. Examples:

"Please explain a little about lumbar puncture and what diseases can be discovered from it."

"How are I. Q. tests used?"

"How can a person overcome chronic alcoholism while in the service?"

"What is the purpose of Sodium emitoll? What are its effects or functions, or what takes place in a person's body to make him act as being drunk?"

"How can occupational therapy aid in the cure of a person who has no inclination for that type of treatment?"

"What can a patient do to overcome anxiety and hysteria if he knows he has that condition?"

These questions were all valuable. They helped explain why certain procedures were employed. They reflected the patients' interests and desires to become well.

The questions covered the entire field of neuropsychiatry and associated medical problems. We have observed that an unusual therapeutic success, especially in relation to conversion symptoms caused by combat, always becomes a topic of discussion. We cannot say from our observation that certain topics should be exclusively used for group psycho-

therapy. Subjects pertaining to the relationship of functional disease to somatic symptoms, and formal lectures in relation to mental mechanisms, should take precedence.

The group psychotherapeutic method will fall far below its successful goal, however, if the other aspects, such as medical subjects, explanation of diagnostic therapeutic procedures, administrative ward or hospital policies, and discussion of psychosomatic problems are not taken into consideration. The discussion of these varied problems pertaining to the field of medicine and neuropsychiatry should not be considered as general information for the patients. It should be realized that the topics always relate to patients' problems in the group with the participation of the patient. The leader or moderator, by first answering the question, can be said to light the fire of therapy, but it is the patients who contribute the fuel to keep the flame burning.

In order to evaluate our results, the patients, without knowledge of their dispositions, were asked the following questions: (1) How many sessions they attended? (2) What did they learn from group therapy? (3) Did they believe group therapy helped them, and if so, in what manner? (4) Which did they prefer, group or individual psychotherapy?

Patients who were high-school graduates or who had had college education were requested to answer the above questions in writing. The others were interviewed and their replies were recorded by a psychiatrist. All questions were filed, in order to determine what information pertaining to neuropsychiatric problems was most desired by the patients.

The number of sessions attended by the patients ranged from three to twenty-four. Thirty-three per cent of the patients attended six to twelve times; 11 per cent, between eighteen and twenty-four times; 56 per cent, from one to six times. It is obvious that the greatest benefit was derived by the patients who attended the greatest number of lectures, everything else being equal.

Despite the apparent success of this method of group therapy, about 14 per cent of the total group stated that they did not learn anything. These patients either exhibited poor attitude during their entire hospital stay, did not have a fair understanding of English, or had practically no school-

ing. However, some of the patients with little formal education stated that they had learned and profited from the sessions. Patients with character disorders admitted that they had derived no benefit. The remaining 86 per cent had profited by learning certain fundamentals of mental-hygiene concepts, mechanisms of mental illness, and general medical information.

Sixty per cent of the patients with a diagnosis of psychoneurosis claimed definite improvement from group therapy as distinguished from individual psychotherapy or other therapeutic procedures. Forty per cent of the psychoneurotic group claimed that, even though they had gained information, group psychotherapy alone had had no effect upon their symptomatology. Only 2 per cent claimed that they preferred group psychotherapy to individual interviews.

Some of the benefits derived from this type of group psychotherapy are best expressed by the patients' written statements:

> "I believe that group therapy is an excellent treatment and that, combined with the necessary amount of private consultation, it will aid men to understand their condition and thus recover, and as such should be continued to its fullest advantage."
>
> "In two months of this sort of treatment I have gained what I consider a very general, but fairly thorough knowledge which is really important to my particular case, but what you yourself would not ask, because to you it sounds silly and unrelated, and so you once again derive benefit from the troubles of others."
>
> "These lectures do much good: 1. They promote a better understanding between doctor and patient. 2. They enlighten the patient in some instances on his particular problem. 3. They give a medical officer a better opportunity to know and understand the type of patients under his care and last, these lectures create faith, faith in your doctor that he knows his business, faith in yourself that you will be cured, having such faith is half the cure."
>
> "I firmly believe that an open discussion based on submitted questions by the patient is more beneficial than a chosen topic that would seem dry and uninteresting to the patient. As a conclusion, I want to say the questions submitted by myself and the others and to which I have secured clear cut and proper answers, have cleared up in my mind many misconceptions that I have carried in regard to many illnesses and toward the misconception as to what a 'psychoneurotic' is."

The question-box method, as described above, is considered a minor modification of the group psychotherapeutic procedure as usually given. However, by this means of a minor

modification, the patients react much more readily than to prescribed formal lectures or case discussions. It gives the patient the opportunity to express his ambivalent feelings without fear of punishment, as the identity of the writer of the query is unknown. The leader or moderator of the group must know the case histories of the patients involved. In this manner he can usually ascertain the identity of the patient asking the question. He then can readily maneuver the discussion so that the individual who asked the particular question takes part. A further advantage of the method is that new patients, within twenty-four to forty-eight hours after admission, can be given group psychotherapy.

It is obvious that the same questions—or questions that lend themselves to similar explanations—are repeated. This is not a drawback, as continual repetition is essential to drive home certain points or ideas because of intellectual or emotional blocking. By our modification, the principles of the dynamics of group psychotherapy—that is, intellectualization, patient-to-patient transference, catharsis, and group interaction—are more successfully handled. We have further, through this method, been able to analyze the information most desired by the patients.

The questions of the patients covered practically every aspect of neuropsychiatry, and, in addition, many general medical subjects which at first did not appear pertinent. On closer investigation, it was noted that for a large number of patients, these general medical questions had more bearing on their problems than did direct neuropsychiatric concepts.

To illustrate, one soldier had a mother who was being treated for cardiac disease. He desired information as to whether his absence from home would aggravate her condition and even possibly contribute toward her death. This patient was abnormally attached to his mother. He had been seen several times previously in private interview. This problem of his had never been mentioned, but noting the questions of the other patients, he had had no hesitancy in placing his query in the question box.

In this case the moderator, after reading the question, at first had no idea as to the identity of the interrogator. During the discussion that followed, the patient volunteered that

he had asked the question and wanted information along that line. Only then did individual interviews with this patient result in rapid amelioration of his gastrointestinal symptoms, with eventual return to duty.

A child who was being reared by a tuberculous wife caused another soldier much anxiety. The fear of the hereditary aspects of many diseases gave rise to much anxiety in others. These examples can be multiplied manifold. We have also learned that our patients had more insight into their problems and gave more intelligent thought to them after attending a few of these sessions.

The benefit derived from the group psychotherapy was directly proportional to the number of sessions attended. This applies only to those patients who were actually helped. A number of intelligent patients with good attitude, but little formal education, did profit from the therapy. The psychoneurotic class of patients derived the greatest benefit. We do not advocate, on the basis of our results, giving group psychotherapy to psychopathic personalities without neurosis, mentally deficient patients, patients with poor attitude, or those whose knowledge of English is too limited. We did not apply group psychotherapy to psychotic patients. Ninety-eight per cent of the patients preferred individual psychotherapy to group psychotherapy. The majority of them favored a combination of both methods. From our results we believe that group psychotherapy should be given in conjunction with individual psychotherapy and other therapeutic procedures.

We believe that the question-box method is particularly well adapted for group psychotherapy with a heterogeneous group of psychoneurotic patients. It is also our opinion that this method can be employed in civilian hospitals as an adjunct in the treatment of psychoneurotic patients.

PATTERN FOR REHABILITATION: THE RÔLE OF THE EDUCATOR

EDWARD LISS, M.D.
New York City

MAN'S social progress is a process of trial and error, slow and frequently regressive, and his best civilized attainments are tenuous and fragile. Under pressure he frequently lapses into the primitive. When hard pushed, he resorts to instruments that, though scientific and altruistic in the making, can be primitive and ruthless in their application. If need be, they are used ruthlessly. There is a perpetual struggle between man's animistic core and the spiritual elements that are the products of his finest thinking, action, and education.

This struggle constitutes the steps in man's learning process, most of which steps he has forgotten, or they have become so much a part of him that he is unaware of them until emergency reflexly uncovers and discloses their submerged presence. With time he has become a planning organism, but essentially he still functions best in uncomplicated physical activity and direct thinking and action. His zestful skills are still body skills or manual skills, and this preference is a persistent one.

The years of infancy, childhood, and adolescence are essentially periods of the dominance of physical skills. There is a core of reverence for the physical, which we see in its narrowest sense when we think of health in terms of physical well-being only. Affirming and reinforcing the old philosophical concept of the interrelationship of soma and psyche, we have recently rediscovered that concept and embodied it in "psychosomatic" medicine.

An awareness of spirit and body-healing has essentially been the concept of the most primitive religions. We see it in the rôle of the healer or medicine man, and in his contemporary parallel, the missionary doctor. There is a con-

stant struggle between the two forces, and the closer the functions of the spirit with healing, the more successful the end result. At the present stage of our evolution, this is particularly to be emphasized, for there is a crisis in man's growth between the primitive and all that has been socially gained. Man's ability to cope with the primitive element and to rise above it will determine his eventual destiny.

The achievement of such a goal entails an about-face in emotional and spiritual values, from a war to a peace basis. Elemental techniques having been stirred up and instrumented, we must now bring them back into civilized grooves. Our emphasis on destruction has been made as scientifically efficient as possible, and with equal scientific acumen we must bring about constructive practices.

To do this, learning is tested to the breaking point, for a shift in emphasis and in values of so profound a nature takes time and resiliency. Yet in the evolution and growth of each human being, just such a revolution has been lived through when in the early education of the child, body interests, from which he derived so much pleasure and which formed so much a part of his world, had to be renounced and repressed when society demanded a reversal in attitudes. Those early values which had been approved as helpful now became taboo except in illness.

Here we have an analogy that to a certain extent represents the present problem in reëducation. We call it *rehabilitation.* In a major social disruption we call it changing over from a war-time to a peace-time psychology.

If we remember that for military efficiency full physical efficiency is needed, then any loss of efficiency through body injuries will require dramatic readjustments. The problem of acceptance or rejection of these handicaps and losses in individuals is in actuality an adjustment in terms of old patterns. Previous life experiences carry in them an inherent, almost a predictable, response. Recent events are part of a sequence; recent losses are reminiscent of old losses, psychic or physical; and current reactions are a review of childhood responses to traumatic phenomena.

Inherent in each situation are many variables because of different biological and environmental factors. The pattern

for conquering anxieties is reviewed and applied for new end results. The law of compensation is called into action and certain responses are repressed, while compensating adjustments are explored in old and new areas. There necessarily follows a period of experimentation, uncertainty, and confusion. Those who have developed previous techniques in the past are fortunate, but for those who are new to such experiences, the element of recovery and adjustment may be infinitely more difficult and stormy.

In the course of our individual therapy, we meet surprising latent talent. Such talent, tenuous as it may be, is often a life-saving activity and tides our patient over the reconstruction period. Time and again, in therapy with children and young adults, when academic subjects are failures, the workshop or the studio can be a life-saving prop against delinquency and neurosis.

Those of us who have had the opportunity to work with the chronically ill fully appreciate that physical cure is but a step toward functioning in life. In some instances the so-called cure is often worse than the original disease, for the illness brings inordinate attention and overprotection to the patient, meeting needs that possibly were not adequately met before. I speak particularly of children who have had the crippling sequelæ of encephalitis or tuberculosis of the bone. The need for rest and immobilization was there, but the by-products of that approach were but little appreciated.

Only comparatively recently have we sensed the detrimental effects of too much rest upon both mind and body. This implies, of course, a revaluation of a broader concept of cure. All too frequently the child, when discharged into an environment in which the demands of everyday living are insisted upon, falls victim to a malaise that is more baffling and time-consuming than the original infection. Activity is a natural product of growth, and growth is most present in youth and in the normal process of tissue repair. It would be interesting to evaluate the emotions that were decisive in the emphasis upon rest beyond the period of its effectiveness. Too much rest can lead eventually to biological and emotional stagnation. Convalescence is not, therefore, a medical problem alone. It must be an educational one as well.

Some years ago, in a discussion of this aspect of illness, I mentioned and emphasized the phenomenon of psychosomatic recapitulation that convalescence inherently brings about, and stated that to stress the physical to the neglect of the psyche is to cover only part of the problem.[1] Just as health involves all fields of human activity, so does cure entail the utilization of all developments and resources in other fields. Delimitations are artificial. They must be broken down and all interests conjoined and brought into the field of action, particularly those that pertain to the things of the spirit and to faith.

The current concept of occupational therapy as an ally needs no elaboration, but one wonders if the contemporary use of the arts and crafts could not be broadened and applied rather more scientifically. This necessitates knowing and utilizing the potentialities and capacities of other fields of action. Occupational therapy and physical therapy should be much more interrelated with the field of education in general. We run into the constant danger that in our specialization there is not enough integration and fusion. The emphasis is still too much on the physical quantum. The physician dealing with chronic illness or with disfiguring illness is confronted by the vision of a large field of possibilities. No longer can he be content with a problem well-solved until all the resources of the individual have been plumbed and utilized, for, after all, constructive functioning and health have much in common.

Now, in as much as most specialists are expert in one field only, they must call upon others to round out a program that will meet these comprehensive needs. A general educator and his pedagogic science should be in the centrum activity. We speak so much of total war, why not of total cure, implying that we have used all of our available resources?

As our knowledge of human psychology expanded, we became aware that the total human being needed our guidance —that our task was only partly accomplished when we had restored physical functioning as fully as possible. The con-

[1] See "Convalescence," by Edward Liss. MENTAL HYGIENE, Vol. 21, pp. 619–22, October, 1937.

valescent discharged into his old environment often felt that there were but two alternatives for him—total inertness or full activity. He was thrown into a quandary, for the first was undesirable, because activity and life were synonymous, and the second—full activity—was a formidable hazard because of his depleted resources.

It is difficult to realize that this was the status of the patient discharged from most institutions devoted to the chronically ill, and is still the case in many institutions to-day. The practice of early activity in convalescence has permeated medicine. Surgical convalescence and obstetrical convalescence are now accelerated. Early activity is encouraged in the care of both old and young, for stasis is a threatening physiological and emotional state. All aspects demand our consideration. The essential contribution of the psychiatrist certainly is reëducation.

To understand the practical aspects involved, we must comprehend the evolution of the human being's techniques. Put simply, they are (1) mechanical, (2) artistic, and (3) intellectual.

Some of the earliest years are spent—increasingly so—in school. Educators have reached back to the nursery and the kindergarten and have evolved techniques for the physical orientation of the child in time and space. Body habits are tied in with time, and body activities with space, so as to permit ease and facility with inherent physical endowment. The emphasis is on one's self as an instrument of energy, which we should learn to use with maximum efficiency, with satisfaction to ourselves and with a minimum of threat to others. Individuation and coöperation are the first steps in socialization, which comes into full flower in the later years.

At the six-year level, when our "formal" education begins, patterns of accomplishment in physical activities have already been attained and human relationships through these practices established. The elementary school elaborates these early skills and social patterns, while formal knowledge is launched and put into function. We might say that the appreciation of symbols and the acquisition of physical techniques are the two elements that are needed. Crude as they may be, the early adventures in the arts and crafts—those

groping experiments with form, color, line, and sound—evolve into more finished patterns where opportunity to experiment has not been curtailed, and individualistic styles are observable and become formulated.

As early as the kindergarten years, this individuality is perceptible. Social growth has its genesis and formulation then. In cultures different from ours, the means of communication often remain in the form of melody and pictograph patterns, and this mode of communication is frequently amazingly rapid and efficient. Such techniques are observed in young children in the nursery and kindergarten, and in the workshop of the growing child. The child psychiatrist applies these techniques and utilizes them for his own information when verbalization falls short of its subsequent finesse. Our play techniques are based upon such knowledge, and the value of this instrument for diagnosis and therapy needs no elaboration.

In therapy with the adult, our occupational-therapy techniques are but elaborations of such early activities. The question is: Are we using those activities for diagnosis and therapy as fully as we should? In ordinary practice the interpretative significance of these activities should be translated into valuable information as to the inner life of the individual. To the child psychiatrist, it is one of his most potent tools for catharsis and diagnosis. The therapeutic and æsthetic components are there, too, as important by-products.

In working with the sick, one sees how the educator and the physician must deal with a common problem, for the sick and the well are individuals of basic interests, differently utilized. The physician perhaps plays a more passive rôle than the educator during the convalescent process, and on the other hand, a more active rôle during the acute phase of illness. The emphasis is different, but the need for coöperation is consistent and constant. The physician is concerned with the physical problems which at that particular time are foremost, and subsequently the educator is called upon, when sublimation of expanding physical energies takes place. One must supplement the other if we hope to integrate the process of growth.

The intellectual pursuits are comparatively late in development. Formally, they begin in the elementary years and receive increasing emphasis in the subsequent years. The secondary schools and the college elaborate this emphasis. It is characteristic that in times of illness the late acquisitions are the first to go and in convalescence the last to come back. Any serious physiological disturbance, whatever the cause and whatever the toxic agent behind it, places increasing stress on body routines and those early phases of human development that we refer to as infantile and childish patterns. It, therefore, follows that the techniques used to cope with these must be appropriate to those periods. In actuality, the pediatrician's viewpoint is well applied at this time. We might say that those individuals who are involved in the healing procedure should be familiar with sound nursery and kindergarten practices, which actually have grown out of modern psychiatry, psychology, and education.

Are not some of the good results of after-care indebted to this concept? One can look forward to perceptibly ameliorated recovery statistics when more detailed care of convalescence is stressed. It is not alone the operating room that determines the survival of the patient. Unfortunately, the physician in the rôle of educator is often handicapped by lack of time, and sometimes by lack of awareness of the importance of such details. Any program is effective in terms of our knowledge, the application of that knowledge, and the coöperation of technical skills.

We now come to the question of personnel and the human denominator that is always present. When we wish to apply our knowledge, the problem of egotism in each individual is a serious one. The artist's egotism is centered upon the finished product and this may defeat the very purpose of the therapy, for the therapeutic values of an activity lie in its inherent cathartic aspect and that particular individualistic free play which is permissible to the creator. Undue stressing of end results frustrates the tender, tentative, exploratory needs of the patient.

To be sure, subsequently the end result, the æsthetic, has its definite function, but at the outset of any activity, the doing or becoming is most important. Therefore, the relega-

tion of the therapist's ego to its proper rôle is an essential requisite to the effectiveness of the program. Another hazard in the educator is his own response to the inner conflicts of the patient. He must be flexible enough to respond to these conflicts, and at the same time must be labile and comparatively free from the common anxieties that are centered around disease in its multiple manifestations.

For some individuals such constellations produce too many anxieties, and result either in restricted vision with regard to the evidence revealed in the process, or in unconscious frustration of the patient's activities and release. Hence the need for basic orientation in human psychology in all who are engaged in therapy, no matter what their backgrounds or their special contributions, vocational or avocational. One sees, therefore, a universal need for a close relationship between those who handle the sick and the environment in which the sick must function. We must appreciate also the sources of the stream of the patient's emotional and physical adjustment and the various stages through which he has lived preceding the traumatic situation now present.

If the problem is of many phases of growth, the indicated procedures must be pertinent to all ages. In other words, if the problem is one of adult education, the techniques vary with the phases of growth through which the individual has regressed and from which he must move forward again, in spite of the fact that he may now be handicapped, burdened by the loss of a part, or the depletion of physiological, emotional, or intellectual functioning. The problem, therefore, will vary with the special dysfunction of the patient and will call for varying emphases and a special approach to cope with the special need.

The foregoing may seem too complex and contrary to the concept that we should not compartmentalize human beings, but in essence it means emphasis rather than specialization, coöperative therapy rather than specialist therapy. It broadens the scope of application instead of narrowing it, and challenges flexibility continually, drawing upon the pool of physiotherapy, occupational therapy, and education, all of them interlacing instead of being compartmentalized against

one another. This, then, is the curriculum for convalescence. If we wish to instrument the holistic philosophy that we now preach in medicine, we must be prepared to cope with the many and varied needs of the individual.

The educator has spent a lifetime in practice and experiment, and his resources are rich and, through trial and error, sound. Just as medicine is under constant revision, while still possessing time-honored, basic values, so is it with the arts and crafts in classical education. Here are potentialities that need continual exploration, if we are to conceive of rehabilitation as the bringing back of an individual to function in society. Tradition and experiment must be interrelated. The resources available are vast; the arts and crafts are just coming into their own as tools, for the sick or the well, for therapy and for mental hygiene. The academic areas in mental therapy and mental hygiene have been more favorably welcomed.

One must envisage the rehabilitation of the future as an amalgam of all knowledge, a university in miniature, in which all knowledge is considered equal. The hospital of the future will be truly hospitable to all knowledge. Those who withdraw from life, for whatever cause, will find sustenance of body and mind, and be able to meet life again equipped with the best that their inner resources permit and that our resources can offer them. Of primary importance is the human equation for the sick and for the healer. After all, the tools available are man's own creations; he produced them, although at times he has not appreciated their potentialities. The more humanistic the approach, the greater the dignity and worth of the finished product. The more worthy the product, the greater the gain to the individual and to society.

WHAT HOSPITALIZATION MEANS TO THE MENTAL PATIENT, THE COMMUNITY, AND THE HOSPITAL SOCIAL WORKER *

HOSPITALIZATION AND THE MENTAL PATIENT

HENRIETTA B. DEWITT

Director of Social Service, Springfield State Hospital, Sykesville, Maryland

ONE of the greatest obstacles to the acceptance of hospitalization that the mentally sick person has to face is the present-day attitude of society toward mental illness. While psychiatry as a scientific branch of medicine has received limited recognition, it is dissociated from the general cultural attitude, which still looks upon mental illness with ignorance, superstition, and prejudice. As a member of society, the patient shares the attitude of the group, and it operates to intensify his feelings of difference as a mentally ill person. He sees in the tragedy that has befallen him a threat not only to the self, but to his status as a member of the group, and the terrible totality of the separation is almost more than he can bear.

Society tolerates the mentally ill person only as long as his sickness is his private affair. He can be as queer as he likes as long as he can maintain his place in the community. He may have his private analyst or attend a psychiatric clinic or even have a "nervous breakdown" in a private institution without losing caste, but as soon as commitment to a state mental hospital becomes imminent, a different set of values begins to operate. He becomes an outcast. A stigma is placed upon him and his family, and he is set apart as different. Even though he recovers sufficiently to return to the community, the disgrace of his unfortunate lot follows him. He is looked upon with suspicion. The hardships he must

* Symposium presented at the First Annual Coördinating Conference at the Western State Psychiatric Institute and Clinic, Pittsburgh, Pennsylvania, April 4–5, 1946.

undergo in order to regain a social status acceptable to him are sometimes insurmountable.

Society looks upon hospitalization as a finality and not as a therapeutic process. It harbors fear of the insane person and is concerned for its own protection. State mental institutions are designed primarily to imprison their inmates and to provide for their care and welfare. They are poorly supported, understaffed, and overcrowded. Little emphasis is placed upon treatment and recovery.

Another obstacle to the acceptance of hospitalization is the existence of antiquated commitment laws. In his sick and confused state, the mentally ill person often feels that he is being treated like a legal offender. It is hard to believe that in some localities mental patients are still subjected to court hearings prior to commitment, and that the permission of the court is necessary to effect their release. Sojourns in jail while awaiting admission, transportation by police, and overprotective parole regulations are also examples of the implied punitive attitude of society.

To the average citizen, the mental institution, with its isolated surroundings and jail-like appearance, is wrapped in mystery. He hears weird stories of harsh treatment and of sane people unlawfully held. He believes that most of the inmates are "wild maniacs," and he would be afraid to walk through the grounds alone. The patients whom he sees strolling about seem as different from him as people from Mars. He does not see them as sick people who may recover and return to the community.

The family physician, as well as the layman, has little understanding of mental illness and the therapeutic aspects of hospital care. He is poorly prepared to help the patient and his family when this catastrophe strikes. If the patient sees himself as sick or "nervous," his physician is apt to treat his physical symptoms with no understanding of the psychological implications. He recommends hospitalization only when all else has failed. He seldom takes the patient into his confidence or has the courage to try to help him face the reality of his necessity, but connives with his relatives to trick him into hospitalization. After commitment he feels relieved of all responsibility.

This to me presents a vital problem because it is the family physician more than any one else who is called upon to interpret mental illness in critical situations. His insecurity and attitude of hopelessness are conveyed to the patient and his family, who are often misled by the confidence they have in him.

To-day commitment to a state mental hospital is usually a traumatic experience both for the patient and for his relatives—sometimes it is even more difficult for the relatives than for the patient, although there are relatives who, consciously or unconsciously, look upon it as an escape from a painful responsibility. In any event, the surrendering of personal liberty on the part of the patient and the relatives' feeling of "putting him away" are hard to face. Regardless of the need or the circumstances that have brought it about, commitment is a measure of desperation—a dead end. It is true, however, that the same intensity of emotion is not associated with all admissions.

Many patients are committed because of a failure in the social structure which supported them rather than as a result of any progressive pathological change in them. These consist of the people with primary or residual defects and some seniles who find their way to state hospitals because something happens to the near relative whose care made is possible for them to live in the community.

The use of the state mental hospital as a refuge for this group has long been questioned, since they present problems that community agencies could solve through recognition of the need for foster-home placement for these adults. They clutter up the family-care programs, or, even worse, occupy beds in the hospital often to the exclusion of the acutely mentally ill. This group also contributes to the lack of initiative and the discouragement with regard to therapy and movement that are sometimes felt by chronic-service physicians. It is hard for the patients, too, especially for the old people who could live in a protected situation in the community instead of having to end their days in a mental hospital.

Then there are patients who, in spite of the fearful implications of commitment, welcome hospitalization. In it they

hope to find a haven from a hostile world and an opportunity to regain sufficient security to go on living. Also, there are patients who feel the need of the protection of hospitalization, yet who have not the courage to admit it even to themselves. They haunt dispensaries or court arrest, unconsciously hoping that their difference will be noticed and that some one will act for them. They come into the hospital protesting, but go willingly enough to the ward.

The group for whom hospitalization is least difficult are the completely disoriented individuals who are seemingly unaware of what is happening to them.

The largest number of patients committed, however, are those who have only partial insight or none at all. Too often they are trapped into coming to the hospital or are brought in by the police. It is these patients to whom commitment seems such a tragic experience. Even if they can admit illness, they do not believe that they belong in a state hospital. They project their feelings upon distressed relatives who identify with the patients' fear and resistance and are overwhelmed with conflicts and feelings of guilt. The relatives have little more conviction than the patients regarding the validity of this step. They find themselves in the admission office, precipitated there by the emergency of their problem. Beset with doubt and bewilderment, all their past concepts of such places converge upon them with the shock of the present reality.

There are few situations in which there is greater need of understanding and reassurance than in the admission office of a state mental hospital. Here is where treatment begins, and the manner in which this service is conducted may determine the success or failure of the patient's entire course in the hospital. Because of the pressure under which state hospitals operate, the importance of the admission service is usually underestimated. Too often cold, impersonal physical surroundings confirm the worst fears of patients and relatives, while indifferent and unskilled handling at the time of admission lends justification to their feelings of hostility and rejection. Here the need is to focus not on the patient's illness alone, but on the problems of the patient as an individual and of the relatives, in relation to admission. Here it

is important that they face together as far as possible the real issues involved and are helped to accept responsibility for their respective rôles in the admission process. To be effective, this service requires the skill of a trained psychiatric social worker as well as that of the psychiatrist.

At Springfield, a social worker receives the patients and their relatives in a warm, attractive admission office. After making an effort to put them at ease, she checks the commitment certificates, and addressing her questions as far as possible directly to the patient, she fills out with his help the statistical sheet. When this form has been completed, the worker talks informally with the patient and his relatives about the rest of the admission procedure, the hospital rules, and the hospital routine.

This interview varies in nature, of course, depending upon the condition of the patient and the problems that the particular situation presents. For instance, if the relative has failed to tell the patient that he is to be admitted to the hospital as a patient, the worker explains the situation, and uses her skill in trying to help the patient and his relatives accept it as a reality.

The physician is then called, and after he has interviewed the patient, he summons a nurse, who appears in a few minutes to take the patient to the ward. Good-byes are said, and when patient, nurse, and physician have left, the worker proceeds to obtain the history from the relatives. The admission process is completed the following day, when the social worker visits the patient on the ward to answer his questions and to break down his feeling of incarceration.

The following case illustrates the rôle of the worker in helping the patient and his relatives to a more realistic acceptance of hospitalization.

> Mrs. Otto, her husband, and her mother-in-law came into the office together. Mrs. Otto was a young, rather shabbily dressed woman, who sat quietly twisting her hands together in her lap. The social worker from St. Andrews Hospital had driven the family to the hospital, as Mrs. Otto was a transfer from there. The social worker handed the papers to me with a hushed air, saying that she would be glad to wait for the family, but that she had only driven them here and had had nothing to do with this.
>
> When I started talking with the patient, her face was wreathed in smiles and the whole family seemed to be unusually cheerful, with a con-

tented air about them. I began by asking the patient if she knew where she was. She shook her head, saying that it certainly did look like a hospital. I explained to her that this was Springfield State Hospital. The husband sat slouched in his chair, apparently not knowing quite what to do.

I asked the patient whether she had known that she was to come here. The mother-in-law explained that they had fooled the patient. The husband nodded and said violently that he had not wanted to do this—that the doctor had felt it wise not to tell her. I said that I wondered if they could tell us just how this had happened. Mr. Otto said hesitantly that the doctor had said this would be a good place to help his wife's nerves.

When Mrs. Otto heard this, she suddenly remarked that this must then be a "crazy house." I explained to her that it was a hospital, a place for people who were nervously and mentally ill. She started crying silently, saying over and over again that she did not feel she belonged in a place like this. The other two were silent.

I explained that she had come here to-day because two doctors felt that she needed to come. Our doctor would be coming to talk to her, too, so she would have a chance to tell him how she felt.

Her husband then said quietly that he felt very badly about his wife's coming here; they had not told him what sort of hospital this was. Then, turning to his wife, he said that if the doctors felt she needed to come here, maybe a short rest would help her.

She stopped crying and asked me how long would she need to stay. I told her that this would depend on how she got along here. I also asked her if she had other questions about the hospital, now that she had come. I gave the visiting rules to the other members of the family, saying that I would answer their questions later.

She hesitated and asked if she could have visitors. I told her the visiting rules and when she heard that she would not be able to see her husband for a month, she broke down again. I was silent a few minutes. Then I suggested that she might like to help us with the face-sheet information. She stopped crying and eagerly answered questions about her name, marital status, and so on.

I asked her if she had any children. She said she had four. She went on to say that she wondered how they would be taken care of if she had to be at this hospital for some time. I asked her husband what his plans were, and he quietly explained to his wife that he hoped his mother could help until something else could be worked out. I told her, too, that she could feel free to write to her husband and that he could write to her.

Then suddenly she added that she had not brought any clothes with her to-day, and what would she do about this? I explained that her husband could mail things to her and that meanwhile we could supply some. She seemed to have more questions. I told her that I would come to see her the following day and at that time we could talk about these matters more in detail. She nodded and completed filling out the blank. She then asked me if she would have a chance to say good-by to her husband. I assured her that she would. With a resigned air, she left the room with her husband close by her.

After she had talked to the doctor, she went quietly to the ward

and I talked with her husband. He came into the office saying that he felt they had done a terrible thing. I asked him what he meant, and he explained that he felt he should have told his wife she was coming to the hospital. He really had known only that this was a hospital for nervous people, not a "crazy house."

I told him again that this was a hospital for those who were ill, mentally ill. I did know that his wife had been sent to one of the quieter wards and that probably by the time he came to visit her, the doctor could talk with him about how she was. He listened eagerly, and when we made a history appointment, agreed to come in at that time.

As he was leaving, he asked about what financial arrangements would be necessary for his wife's care. He explained that after the war, he had been out of work for some time and was afraid that he could not pay for his wife's hospitalization. I suggested that he could work this out with the department of public welfare. He said that he knew his wife would worry about that, too. He thanked me as he left, saying that he felt much better now about leaving her here.

The following day, when I went to see Mrs. Otto, she greeted me warmly. She said that she wanted to talk to me about some of the things that had happened to her. She was neatly dressed in one of the state dresses and had no make-up on. I asked her how she felt about being here in the hospital. She said that she did not feel that she belonged here. The people here all seemed so very peculiar. I agreed with her that it was very difficult to get used to.

I asked her if she would like to tell me how she happened to come here—just what did happen. She explained that she had gone to St. Andrews Hospital for a rest and that she had known nothing about coming here. I asked her if she could tell me exactly what had happened. She explained that the social worker had come and told her to get dressed—that they were taking a ride, and that it would help her.

I nodded and said that the worker had told me that she had not told Mrs. Otto she was coming to the hospital on the doctor's advice. She shook her head. I asked her how she would have felt if she had known. She said indignantly that of course she would not have liked it, but she would at least have known what was going to happen to her. It would not have been such a shock. I told her that it certainly must feel as if a terrible thing had happened to her. I wondered what she was going to do now while she was at the hospital.

She listened quietly and said that after all she did not need another physical examination because she had already had one at St. Andrews. I asked her if she felt we could help her at all. She said frankly that she did not see anything here that could help her, but she was going to do her best to get along. I appreciated how she must feel about it and added that she could do pretty much as she wanted here, and that we were here to try to help her get out of the hospital and return to her family. She nodded and said that she was worrying about her children. She had written her husband the previous evening to see what arrangements he was making for their care. I asked her if there was any one who could be counted on to help. She said that her mother-in-law would help, for a while anyway, but that she was not well either.

I also explained that I might be seeing her husband before visiting

day and would talk with her about that later. She said that she would like to know about the clothes she had left at the other hospital. She would like to wear her own things and asked if I would tell her husband to send her clothes to her. I said I would, but also suggested that she write to ask him for just exactly what she wanted.

She went on then to ask how the expense of her care would be met. I explained to her just what could be arranged and she said that she knew her husband could not pay for it. At this point I asked her if she had talked over most of the things that worried her and she nodded, thanking me warmly and adding that she felt much better, having talked to me.

The help that this woman and her husband received during the admission process not only helped them clarify their relationship to each other, but formed a sound basis for their relationship to the hospital. Imagine this patient's anxiety if she had found herself locked on the ward with the added anonymity of state clothing and so many vital questions unanswered. Many of her doubts regarding hospitalization, the care of her children, her clothing, and her financial responsibility could not have been answered satisfactorily by the nurses or the ward physician. It is likely that her husband, for fear of upsetting her, would have answered her letters with meaningless reassurances.

Having started on a sound and frank basis, the patient and relative are helped to move step by step toward an acceptance of the reality of their situation. The support that the patient finds in the protection of the hospital environment replaces rejecting community attitudes, and gradually, with the aid of what therapy is available, he begins to regain security. He may never recover sufficiently to leave the hospital or he may. Considering the limitations under which state hospitals are forced to operate, a surprising number of patients do recover and leave.

Until the discovery of the various shock therapies, recovery from mental illness was appreciably slower and it was necessary for patients to remain in the hospital for longer periods of time. Now physicians and relatives alike are stimulated by the remarkably rapid change they observe in many patients and can see leaving as a reality. Furthermore, many patients are now ready to leave before they have had an opportunity to take root in the hospital. In many state hospitals, however, especially on the chronic services, the old

situation still exists. Change in patients is slow, and in the meantime they become useful and are given little help toward leaving.

While the patient's usefulness often operates to keep him in the institution, yet the very fact of his feeling needed is probably the greatest dynamic to recovery that the state hospital has to offer. Many physicians, probably somewhat motivated by the security that they personally find in the institutional setting, are inclined to hold on to patients too long. Complexities of community living loom large, and they are loath to see patients who are well adjusted in the hospital leave and experience possible failure. Therefore, when there are no interested relatives or adequate social-service departments, patients tend to remain overlong in the hospital.

Return to the community is indeed a threatening experience for the recovering mental patient. He may approach it with all the insecurity of a person recovering from an illness, or he may prefer to regard himself as never having been sick, but in either event he is fearful of the rejecting attitudes of society and the overprotection that the hospital seems to exercise over him. He dislikes the fact that physicians are inclined to plan for him instead of with him, and resents the apparent lack of confidence of the hospital in his ability to act as a responsible individual.

An adequate social-service department, in its understanding both of hospital and of community facilities, can do much to break down the separation that exists between them and to combat alike hospital overprotection and community rejection. The social worker is related to the individual patient as he is able to function in a practical situation, and with her knowledge of the community and its resources, can often help him realistically to take the first steps into the community. It is unfortunate for state-hospital patients that the recognition of the need for psychiatric social work in these institutions is not greater.

The community is skeptical of the returning patient's ability to get along. It sees only his difference and is unwilling to accept him as responsible within his apparent limitations. Family physicians and social workers rarely see the

recovering individual in relation to his particular family, but only the problem he presented prior to hospitalization, and regularly express their fears of his influence on family members. Although prior to his illness his difference went unnoticed, they are unwilling to accept it, once it has been labeled insanity. Unidentified, he may be able to find a room or a job, but if he frankly admits that he is on parole from a mental hospital, he has a difficult time.

Parole is regarded by the hospital as a convalescent period during which the patient's condition is evaluated by the way in which he is able to adjust in the community and handle his problems in personal relationships. To the community, parole from a state mental hospital is not very different from parole from prison. Its authority is looked upon as a means of controlling the patient's behavior. When he gets into trouble, instead of allowing him to accept responsibility for his behavior and experience its consequences, the first reaction is to try to return him to the hospital. Just the fact of his being on parole is sufficient to create prejudice against him when problems arise.

The punitive connotation that the term, "parole," carries no doubt accounts to some extent for the general misinterpretation of its function. For this reason some states have substituted such terms as "on furlough," "on visit," or "on leave."

The rôle of the relatives frequently proves a vital factor in the patient's adjustment on parole. This is particularly true in situations in which the patient feels needed and has a real place in the home. There are many instances in which the relatives are no longer interested in the patient, or in which the patient has been hospitalized for so many years that they of necessity have had to plan their lives without him. In good faith they have kept unpleasant facts from him and as a consequence their relationship has grown progressively unreal.

If relatives can learn to deal with the patient frankly and respect his integrity as an individual, he will then have a basis of security in reality on which he can build. Therefore, when he becomes ready for parole, painful situations, such as the one I am about to describe, could never arise.

Mrs. Sponsor was admitted to Springfield in May, 1925, with a diagnosis of schizophrenia, paranoid type. She was then thirty-four years old, married, and had two girls, aged six and eight. She had been a responsible wife and mother until several months prior to hospitalization. One year after her admission her husband took her home against medical advice, but had to return her to the hospital. For years she remained hallucinated, but was an efficient worker in the hospital's sewing room. Her daughters remained interested in her and continued to visit.

Gradually her mental symptoms disappeared and she talked of going to live with one of her daughters, both of whom were now married and had children. They, however, kept postponing the time when they would be able to take her.

On October 5, 1944, at the age of fifty-four, she was presented to our social planning staff with the request that the social-service department get into contact with the daughters to see if they could take their mother, since she was now able to leave the hospital and wanted to live with one of them. The case was assigned to a worker who, after seeing the patient, visited one of the daughters. The following is an excerpt from the first interview with the daughter:

"Mrs. Brown said that she was glad that I had come because ever since receiving the letter from the hospital saying that her mother could be released, she had been so disturbed over the situation that her stomach had become upset. She and her sister did not know what would be best to do. They had thought of their mother as always remaining in the hospital and had not told any of their friends about her illness or even that she was living. Mrs. Brown would not object to having her mother in the home, but her husband would, thinking that her influence upon the children would not be good. He had never met Mrs. Sponsor, and Mrs. Brown could easily see how he would feel that way.

"Mrs. Brown was torn between her responsibility to her mother and to her own family. She lives in a small four-room apartment. She has two small daughters and much of her time is taken up with them. I could see that with her housework and the two children, she did have a great deal to do. Mrs. Brown's sister, Mrs. Kramer, was situated equally as badly as far as taking her mother was concerned. Mrs. Kramer's husband has just been sent overseas and it is necessary for her to work to be able to meet her expenses. She has a small three-room apartment and puts her little daughter in nursery school.

"Another thing that would complicate matters would be her father. It was his understanding years ago that Mrs. Sponsor's illness would be permanent and the chances were she would never leave the hospital. He had obtained a divorce, had remarried, and the stepmother was very close to Mrs. Kramer and Mrs. Brown. If Mrs. Sponsor lives in the home of either daughter, it will necessarily interfere with the relationship between them and their father and stepmother.

"I told Mrs. Brown that I did not think their mother realized that her daughters were seeing very much of their father. Mrs. Brown was sure that her mother did not realize it because they did not speak of their father to her. When they came to see her, they tried to talk of pleasant things, wanting to make her as happy as possible.

"I said that Mrs. Sponsor seemed very sure that her daughters could arrange to take her and had told me that they had invited her to come. I asked Mrs. Brown if they had made her feel that she could come home whenever she was well. Mrs. Brown replied that she had told her mother that she could come home whenever she was able. They had said this, trying to make her feel better, thinking all along that she would never be able to leave the hospital. That was one thing that made it so difficult for them.

"At this point Mrs. Brown began to cry. I told her that I understood how she felt that her first responsibility was to her children and her husband, and that she need not have guilt feelings about that. Mrs. Brown seemed to feel better. I pointed out how much better her mother was and what good work she had done in the sewing room, but that after being in the hospital so many years, it would be quite a change to come into a home and to live in an urban community.

"Mrs. Brown realized all this and said that she wanted to assume responsibility for her mother, but she did not see how she could face some of the problems that had to be faced. I asked her if she and her sister had any other suggestions to make.

"Mrs. Brown wondered about the possibilities of putting her mother in a convalescent home and perhaps trying to get help from some Jewish society. I said that might be one solution and also suggested finding her a place in a private home where she would help a little with the sewing or perhaps just pay board. I asked Mrs. Brown how she felt about such a plan, pointing out that after her mother had been out of the hospital for a while, she and her sister could see what kind of adjustment their mother made and whether they felt that they could take her into their homes.

"Mrs. Brown said that she thought that would be a wonderful plan—that if her mother could get used to staying out of the hospital, she could visit them occasionally and their friends could get accustomed to knowing that they had a mother. After further discussion, she agreed that she and her sister should be the ones to explain the true situation to their mother. They planned to visit her the following week."

By recognizing with the patient's daughter the real problem this situation presented, the social worker was able to help her release her guilt feelings and look at the problem objectively. The daughter was then free to bring out her real desire to help her mother in the way that was possible for her. However, much of the pain and anxiety could have been avoided had the daughters followed a more realistic course from the beginning.

In this paper I have presented what seem to me to be the basic problems that confront the mentally ill person in relation to his commitment to a state mental hospital—namely, the attitude of our culture toward mental illness, and the

lack of wholehearted recognition accorded psychiatry by the medical profession. Cultural attitudes, I believe, will change as medicine leads the way.

New terms have been invented to describe new concepts and much time and effort is being spent on disseminating mental-hygiene information, but not until the medical profession places the same emphasis on sound psychiatric training as it does on other branches of medicine will state mental hospitals become institutions of treatment and research. Many of their fearful aspects for patient, relative, and physician will then disappear. This has been proved by the greater ease with which the mentally ill person is now able to accept care in a private mental hospital, in which the emphasis is placed on therapy and commitment is more often on a voluntary basis.

The pathway to this goal lies, as I see it, along the lines now represented by what we call psychosomatic medicine. As this approach becomes generally accepted, the status of psychiatry will be recognized as an integral specialty of medicine itself.

THE MENTAL PATIENT IN THE COMMUNITY FROM THE VIEWPOINT OF THE FAMILY AGENCY

NORMA LEVINE

District Supervisor, Family Society, Pittsburgh, Pennsylvania

FAMILY case-workers are concerned with psychiatric problems from a point of view different from that of the psychiatric social worker who is part of the staff of a hospital. Although Miss Gartland will discuss with you more fully the rôle of the psychiatric social worker, it is necessary here to state that I see the psychiatric social worker's function as that of enabling the patient to use the services of the institution.

These services may, and often do, extend beyond the walls of the hospital, and they may, and frequently do, include working with members of the family other than the patient. But whether her work be intra- or extramural, whether it be

work directly with the patient or with some member of his family, the psychiatric social worker always keeps her focus on the patient. Everything she does is oriented to her first consideration of how it will affect the patient in relation to his mental illness or, hopefully, his mental health.

Thus she may concern herself with a problem of marital difficulty if it has become clear that tensions between husband and wife affect her patient, sometimes even to the point of determining whether the patient can return home. If, on the other hand, there are marital difficulties in a family and the patient's prognosis indicates that he will not return to his family, she will not offer service in regard to the marital difficulty. She may, on the other hand, refer such a family, if they are ready for it, to a family agency. Even in the first instance—when the patient will return to his home—the psychiatric social worker may refer the family to some other community agency for specific services. She might well refer them to the family agency for help in problems centering around family relationships or for such specific services as help in financial planning, vocational adjustment, home-maker service, and so on.

The family case-worker functions in many situations in which mental illness is a factor—for instance, in 1945, mental illness was a problem in 327 families served by the Family Society of Allegheny County—but her focus is on the family group and each member of the family as part of that group. As its broad purpose, the family agency is organized to maintain and to develop healthy family life. We may, and often do, work primarily with one or two members of the family, but we are always concerned with the total group.

We render services to help with problems that affect the equilibrium of family life, including case-work help with emotional problems in situations in which there is discord between husband and wife or parents and children; or in which for some reason, perhaps because of physical or mental illness, the father or mother cannot continue to carry responsibilities; or in which help is needed in problems of household management, the budgeting of income, and the training and disciplining of children. The family agency may help also in situations in which the mother has died or is absent

from the home and a substitute home-maker may enable the father to keep the home together; or in which the family is faced with new adjustments, as now in the post-war period, and agency services are needed to maintain the best possible level of family life.

The family case-worker, like the psychiatric case-worker, has had full professional preparation for social work—*i.e.*, a two-year postgraduate course in an accredited school of social work. Her professional preparation includes some knowledge of the dynamics of mental illness and she is familiar with the symptoms of mental illness as well as some of the methods of treatment. She may or may not have had experience in a psychiatric setting that would include an opportunity to observe and perhaps work with psychotic patients. She has also an awareness of how one ill or upset person may affect the members of a family group, and of the serious, long-time responsibilities placed upon the family members closest to the patient.

Families in which there is severe emotional upset or mental illness may need the services of a family agency at various points. Sometimes before a diagnosis is made they are concerned about the patient's behavior and need help in understanding and seeking treatment for the illness; sometimes during the patient's hospitalization, they need help in making the necessary readjustments; and often when the patient is discharged, they need assistance in meeting difficulties that may arise.

Many people come to the family agency because they are worried about their own mental health or—probably more frequently—because they are worried about the mental health of some other member of the family. Naturally, not all of these situations involve hospitalization and some do not involve mental illness. We may find that an irate husband, because he doesn't like some of the things his wife does, decides that her behavior is "crazy." Or perhaps a troubled, hostile parent, unable to control the behavior of his adolescent daughter, becomes certain that she is "just like Aunt Susie who is at Mayview."

Although they do not involve actual mental illness, these situations do require on the part of the case-worker an ability

to recognize and to understand the symptoms of mental illness, as well as in the first instance helping the husband use family-agency services in regard to his marital problem, and in the second, helping both the parents and the adolescent child to make some adjustment.

Our work with a person not mentally ill, but severely disturbed emotionally, is illustrated by the case of Mr. X.

> Mr. X., in his forties, the father of four children, had always been a steady, stable person, who worked regularly at his civil-service job and led a well-ordered life. For a period of about six weeks before he and his wife came to us for help, Mr. X. had been sleeping very poorly, and was becoming increasingly irritable and impatient with other members of the family. There was suggestion of auditory hallucinations. He always heard his "voices" at night when he couldn't sleep. Often he would prowl around during the night, awakening other members of the family and becoming increasingly upset himself.
>
> Mr. X. was seen by a psychiatrist, with whom he had several interviews. He was given sedatives and a diagnosis of "no psychosis" was made. For many reasons the psychiatrist could not see him frequently enough to develop a helpful relationship, and finally Mr. X. was returning primarily for the sedatives, which were of great help to him.
>
> As he was able to establish a relationship of trust and confidence in the family case-worker, he talked with increasing freedom about his worries and his dissatisfaction with himself. For the first time in his life, Mr. X. found himself in debt and to him that represented total failure. He couldn't believe that this had actually happened to him, couldn't see his way out, and talked of leaving the family or committing suicide.
>
> During the past year the family had had a series of reverses, primarily illnesses which were a severe financial drain. Two of the children had had mastoids, another youngster had had a tonsillectomy, and his wife had been in bed with "flu" for two weeks. These unusual expenses had led not only to the accumulation of debts, but to a breakdown in Mr. X.'s carefully systematized scheme of budgeting, which was of more importance to him than he knew. Also, his increasing upset had led to inability to work, so at the very time when he needed it most, his income was reduced.
>
> Sharing these worries with a person who still accepted him helped Mr. X., and in addition we were able to help him relieve some of the external pressures. A readjustment of his debts and financial assistance from our agency helped him get started on a plan to work himself out of what had seemed to him a hopeless situation. At present he is again working steadily and is on his way back to the adjustment that preceded his symptoms.

We also work with families in which a mentally ill person is in the home, and here our services are often directed toward helping the responsible members of the family secure treatment for the patient, as in the case of Miss B.

Miss B., aged twenty-one years, came to us at the suggestion of an attorney to whom she had gone because she wanted to take court action against her parents and have them imprisoned or committed to a mental institution. She was convinced that her mother had kept her under the influence of drugs and was trying to poison her. She has two locks on her door to protect her from her parents. She had been going desperately from one person to another to solicit help and by the time she reached the family agency, she had already been to various doctors, lawyers, the police, and so on.

We learned that the patient had had a two-weeks period of hospitalization in a private institution in another state and that a diagnosis of schizophrenia with guarded prognosis had been made. Shock therapy was recommended, but her parents, at her insistence, had removed her from the institution against medical advice.

Her father, who was in the home, had been institutionalized in the same out-of-state private hospital. His diagnosis had been manic-depressive mixed, with recurring periods of agitated depression. He had been a patient in the hospital for nine months and had left with his condition unimproved. He now seemed fairly well able to function, with his wife's support and protection.

The only other member of the family—Mrs. B., the mother—had little insight into her daughter's illness and was afraid to learn anything about it. When we first talked with her, she was certain that the girl's condition had been caused by the hospitalization and that "all that Rebecca needs is a job."

In an effort to have her parents committed, Miss B. finally did go to a private psychiatrist, whom she saw in his office and who indicated to us that she should be institutionalized. However, another interview was indicated before steps for commitment could be taken.

Miss B. did not return to the doctor because he had not "done anything to have her parents commmitted," and her mother has so far refused to go with her to the doctor.

Our service here is that of helping the mother to understand the mental illness of her daughter and to consider possible commitment for treatment. The case-worker must understand that Mrs. B.'s suffering and indecision stem from her unconscious guilt and hostility to the patient. At this point she sees commitment as punishment for her daughter rather than as helping her, but she is slowly achieving an increasing understanding of the mental illness and of her own ambivalence.

If we had available observation facilities—the need for which I am sure this conference has already discussed—many patients would obtain treatment at a point where they are better able to use it than they are after a psychosis has developed. With our present set-up, the patient either must be diagnosed as psychotic or commit a crime before he can have the benefit of psychiatric study in a hospital.

If his condition is a border-line one—*i.e.*, if no frank psy-

chosis can be identified—he often must get worse before psychiatric treatment is available to him.

A case in which the family agency and the psychiatric-social-work department worked together is found in the A. family.

The A. family were referred to us by Morals Court, after Mr. A.'s arrest, his wife having accused him of physical abuse and failure to provide. Mrs. A. was in her seventh pregnancy. There was severe marital discord based partly on the fact that Mr. A.'s mother lived with them and that Mrs. A. was extremely jealous of her.

As her pregnancy advanced, Mrs. A. showed increasingly marked symptoms of emotional disturbance and about two weeks after the birth of the child, she became manic and uncontrollable, finally attempting to throw herself and the baby in front of a street car. She was committed to a state institution, where an original diagnosis of schizophrenic, paranoid, was made.

During his wife's absence from home, Mr. A. seemed completely helpless in planning for the care of the seven children. His mother moved out of the home and refused to take any responsibility for helping. A neighbor cared for the infant, but there was no provision for the other children, who were not attending school or receiving proper care.

Our work with Mr. A. was aimed at helping him make some plan for himself and the children. In the early stages of Mrs. A.'s hospitalization, it seemed that she might return to the home within a two or three months' period, and during that time plans were oriented toward her return. Because no household help was available, Mr. A. remained home from work to care for the house and youngsters. He was helped to obtain financial assistance from the Allegheny County Board of Assistance, showed progress in caring for the home and children, and was finally able to return them to school. There were many difficulties, because he saw no signs that Mrs. A. was getting better, but at the same time he needed her at home so badly that he insisted she was well and should leave the hospital. In addition, Mrs. A. was begging him to take her home and threatening suicide if he did not do so.

These questions and fears he was helped to take to the psychiatric social worker on the staff of the institution. Because she was part of the hospital, knew the patient, had access to the psychiatrist for conferences as frequently as needed, and knew the meaning and purpose of certain routines as well as the treatment procedures, she was best able to help Mr. A. understand his wife's illness and prognosis and the hospital experience.

During the time of preparation for Mrs. A.'s discharge, and finally when she returned to the home, the family worker and psychiatric worker shared the information each had. We needed to know the doctor's recommendation about how much and what kind of care the patient would require at home, and what could be expected of her in regard to home responsibilities. We needed also to have some idea as to what symptoms to expect and what behavior might indicate need for further treatment. We made available to the psychiatric case-worker informa-

tion about current conditions in the home, so that Mrs. A.'s discharge was correlated with the reality to which she was returning.

During the past year, Mrs. A. has been at home, and has gradually assumed responsibility for care of the children and household, and the very assumption of these duties has been therapeutic. She needs to be helped to go slowly—testing herself at every step. Mrs. A. has made an excellent adjustment; in fact, a much better one than she had achieved for many years before her hospitalization. In the hospital she learned new standards of cleanliness and dress.

She uses our services in budget planning, and the planning of nutritious, regular meals, as well as in child care.

Mr. A. has returned to work. This change in his wife, which actually represents for Mrs. A. much improvement, is creating a serious problem for her husband. "Amy got too many newfangled ideas in that hospital. She makes me hang up my coat and wipe my shoes and she wants money for milk and fresh vegetables." In fact, Mr. A. isn't so sure he didn't like his wife better before she got well. Our work with Mr. A. is focused on helping him make his adjustment to Mrs. A.'s mental health and to carrying responsibility as wage-earner, father, and husband.

At the time of Mrs. A.'s discharge from the hospital one of the recommendations had been the prevention of future pregnancies. However, for religious reasons, she could not accept this, and it was finally determined, jointly with the psychiatric social worker, that the strain and guilt engendered by contraceptive methods would be more than she should risk. After a period of months at home, she again became pregnant and seemed to welcome the pregnancy, although it stirred up some fears of recurring mental illness.

The psychiatric social worker was immediately informed of this and although at her next examination at the out-patient department Mrs. A.'s condition continued to be excellent, it was decided that the parole period should be extended beyond the time of delivery. The psychiatric social worker was able to help Mrs. A. see this as a protection for her and actually Mrs. A. has gained strength from her knowledge that if she does become ill, she can go back to the psychiatric hospital if necessary.

I have presented three cases which illustrate our work with (1) an emotionally upset, but not mentally ill person; (2) a family in which we are helping a mother understand her mentally ill daughter as well as herself, so that the patient may secure treatment; and (3) a family in which the mother became mentally ill, was institutionalized, and returned home to make her adjustment in the family and the community.

This paper should not be concluded without some comments on the reference of cases by the psychiatric social worker to the family case-worker. I am thinking here of situations in which the patient is referred at the time of discharge for services that will help him adjust in the community. Thought-

ful joint consideration must be given to many factors—for example, the patient's readiness to terminate his connection with the hospital and his understanding of why he is going to another agency and how that agency differs from the hospital, and the family's readiness to accept the services of another agency. Information about the patient's illness and prognosis—and not only recommendations, but the reasons for those recommendations—must be shared freely. The family case-worker must also share information as to her agency's services, and this requires between the two workers a relationship of mutual trust and respect, each for the other's services.

To facilitate this process of "working together," the family case-worker should have an awareness that even psychiatrists are not omnipotent, that diagnoses are often followed by a question mark, that prognoses are often guarded, and, in addition, that the psychiatric social worker's effectiveness will depend somewhat on whether she is really accepted and used as a member of the hospital team of psychiatrist, nurse, psychologist, and social worker.

THE PSYCHIATRIC SOCIAL WORKER IN A MENTAL HOSPITAL

RUTH GARTLAND

Professor of Social Case-Work, School of Applied Social Sciences, University of Pittsburgh

IN THIS discussion to-day we have become more sensitively aware of the patient who is mentally ill and of the meaning of his illness to him. We have seen him, too, in his social situation—his family, neighborhood, and community—and have viewed him dynamically as he has moved through this experience with illness, before, during, and after his period of hospitalization.

The very fact of our doing this represents change and progress, for some of us can remember the day when we saw the *illness,* but not the *patient with the illness;* when we spoke of catatonics, paranoiacs, epileptics, and our words reflected

our failure to see this patient with this illness as different from another patient with this illness; when we forgot the dynamic quality of life and seldom saw the process in which the patient was engaged as he moved through time and experience. He was a static symbol of an illness instead of a person with rights and responsibilities, and we isolated him from our world.

It is encouraging to see him as a whole person in his social situation dealing with life's problems as we must deal with them within our physical and intellectual and emotional capacities. We have restored him to relationship with his world, our world, and have faced anew the social problems that have led to his illness and the social problems that the illness itself brings in its wake—to him, to his family, and to his community. We have seen some of the services that the professional family social worker can offer to any family in the community to help them deal with these social problems which threaten not only their individual well-being, but that of the community as well.

I would like to reinforce Mrs. Levine's plea for observational facilities in all hospitals. There is a hospital in London where any one, when feeling nervous, can walk in and see a psychiatrist as he could any other physician.

I have been asked to consider with you now some of the services that the psychiatric social worker in the hospital may offer to the patient, to his relatives, and to the hospital as an entity and in its relationship to the community of which it is a part.

It is obvious that the services that any professional person offers are directly related to his knowledge and skill, as well as to the purposes of the profession that he represents. Because there are seventy thousand social workers in the United States, of whom only about ten thousand have had graduate professional preparation through class and field instruction in an accredited school of social work connected with a university, it is necessary to distinguish between the social worker with professional education and those without. I am discussing here the services of the professional psychiatric social worker who has had two years of professional education after college graduation, and who has not only acquired

knowledge from medicine, psychology, psychiatry, and social-welfare organization, but also has developed skill in the use of this knowledge and of herself in a consciously controlled helping process in the area of social difficulties.

The psychiatric social worker is an integral part of the hospital staff and is there because its administration has recognized the connection between the illness of the patient and his social situation. She integrates the services of her profession with those of the professions of medicine, psychology, and psychiatric nursing, at the same time keeping clearly in mind the unique contribution of each, based upon its knowledge and skill and purpose.

Mental illness creates social difficulties for the patient and for those near to him, and social difficulties often create or at least enhance emotional difficulties. This means that the social worker must give attention to the social aspects of a patient's life if treatment is to be useful. It was tacitly recognized by the military in our recent war that a patient's recovery is not wholly dependent upon medical and nursing care. One of the basic generalizations of modern psychiatry is that people who are suffering from mental illness are not a distinct group. Instead, it is widely accepted that most mental disorders represent a way in which the biological organism adjusts itself to the demands of social life, and that psychotic individuals are only displaying in extreme form the behavior that, in lesser degree, characterizes many people who find difficulty in accommodating themselves to other people and in living and working with them, because both of inner tensions and of outer pressures.

Since 1905, social work has been a part of some hospitals because of this recognition that adequate medical care must take account of the social problems connected with illness, but many changes have taken place in the functions of psychiatric and medical social workers since then. The psychiatrists who first used social workers sought data about the social environment and the behavior of their patients as evidence on which to base diagnoses and treatment plans. This point of view was first developed by Adolf Meyer and was a direct corollary of his theories about mental illness. Another use was that of creating for the patient who had

been discharged from the hospital an environment in which emotional strain would be at a minimum. For the most part the administrators in mental hospitals still expect social work to be practiced in this way.

The social worker is seen as the psychiatrist's aid, and the idea is that she should work under his direction. Emphasis is put upon doing things for the patient, with the planning largely in the hands of the psychiatrist. The desires of the patient and of those who live with him are taken into account chiefly because it is necessary to secure their coöperation. The objective of the work is the patient's welfare, but it is held not only that the doctor knows best, but that pressure and influence are justifiable means to use in affecting medically desirable changes.

The development of psychiatric theory in the direction of giving more attention to the dynamics of human behavior, influenced both psychiatry and social work. Social work, too, was developing more consciousness of the contribution it had to make in its own right. While it was still concerned about the social problems related to the illness, its emphasis shifted from gathering facts *about* these problems for study only, and from planning and doing *for* the patient and his relatives, to a dynamic helping process based upon a belief that even psychotic individuals, especially those ready to leave the hospital, can best be helped by working *with* them rather than for them.

This development has influenced both the information-gathering and the social-treatment aspects of psychiatric social work. Relatives and patients who are sufficiently in touch with reality are seen for the purpose of helping them discuss the social difficulties they encounter in relation to the illness in the present, and of enabling them to deal with those difficulties before they become insurmountable obstacles in the path of the patient's return to healthful social functioning within the limits of his capacities.

The gathering of necessary information about the past comes as part of this helping process, and the social worker contributes to diagnosis through observation of the present relationships of the patient with people as reflections of his relationships in childhood. Social work and psychiatry are

regarded as independent approaches to a patient's problems, and the social worker does not so much work under a psychiatrist's direction as contribute the knowledge and skill of her own profession in an independent capacity. Administratively, of course, she makes this contribution as an integral part of the hospital structure and unites her independent contribution with that made by members of other professions to form a related whole, to the end of helping the hospital fulfill its purpose of improved health and continued health for its patients.

To make this more specific, I see the psychiatric social worker at the door of the hospital. If we use the concepts we have discussed earlier in this session, we see the patient—similar to, yet different from, all other patients—as he enters the hospital, separating himself from the old social situation, and moving into a new one, which is the hospital itself; needing to deal with the social difficulties that separation and newness bring; needing to relate to the new as he uses it for health and then needing to leave it to return to the more complex, less protected, social situation of the family and community life, which in the interim has become new to him.

What can the psychiatric social worker offer him at the beginning of this experience? First, she can help make the unknown social environment of the hospital the known. She can help him express any difficulties he is having in relating to and in using this environment. Often she can help him, or the well part of him, to keep related to some of the realities of the wider social environment from which he came, and gradually to look forward to his return to it, planning with her, discarding, changing, and choosing other plans as the social situation changes, and being helped to deal with these changes as realistically as his illness permits.

It is her responsibility to diagnose his social difficulties and his progress in relating to the social environment of the hospital. If she can help him with these social difficulties, with the social problems related to working and playing in this protected environment, she may prepare him to meet social problems in the wider community with more understanding of himself and of others.

Because of her continuous support and acceptance of his

sick and his well self, her non-judgmental, understanding attitudes, her knowledge of the obstacles in the way of his social adjustment, and her help in getting over these hurdles one by one, the patient may gain increased self-confidence and courage to face the world outside in spite of certain handicaps. She can individualize him for the hospital and help him use the hospital's health program. As Mrs. DeWitt has so aptly put it, "Even at the time of admission, she is implicitly related to his leaving and is able to inject a positive attitude that carries beyond hospitalization to parole." I hope that some day we can call parole "convalescence."

The relatives, too, she may meet at the door, and few interviews require greater understanding and skill. To understand, to feel *with,* yet not *like;* to avoid adding her anxieties to theirs and so doubling their burden; to be able to help them with their fear and possible guilt in relation to the patient, with their fear for themselves; to help them to a frank acceptance of the illness with the patient and others; to help them enable the patient to use the hospital, to make of this ending a new beginning for the patient and for themselves in bringing about changes that will create a more favorable psychological and social environment—all this takes more than warmth, sympathy, good will, and a knowledge of social agencies, important as these are. As Helen Witmer has said, "To sense what a person is trying to say, to create a situation in which he can say it and to keep one's own feelings and opinions from interfering with another person's expressions of emotions and attitudes requires a great skill and disciplined sensitivity and a flexible use of one's relationship with a patient or a relative."

Another service that the psychiatric social worker can offer is the development of a family-care program. For some patients, the first step from the hospital in the period of convalescence can best be taken, not in the environment whose social problems contributed to the illness, but in a foster home selected and supervised by the psychiatric social worker, who uses her knowledge and skill to enable the family to give the patient what he needs and the patient to use this form of protected family care as a first step in social functioning.

Part of her function, also, is to help patients and sometimes

relatives during the convalescent period to use other social, educational, recreational, vocational, and health agencies in the community. Mental ill health is often all-pervasive, so that help in many social areas is required, with the hospital social worker contributing her skills concurrently with family and children's social workers, school social workers, and others. She has a responsibility for interpreting the hospital program to the community and the community and its social needs to the hospital. She must interpret with sympathy and understanding the mentally ill patient in such a way as to enable the community to accept and help him with his social adjustment.

Her social-work knowledge and skill should be used by the administration of the hospital in joint planning and the formulation of hospital policies and procedures.

I would hope that she might stimulate round-table conferences, in which the psychiatrist, the psychologist, the nurse, and the social worker would achieve real coördination of knowledge and skill for the benefit of the patients they have in common. These should be frequent and informal and at strategic points in the treatment process.

Last, but not least, she should be a part of the research program of the hospital, relating social research to medical research.

Illustrations of what student psychiatric social workers meet at the door of the hospital are numerous. Time permits mention of only a few. When helping a relative, who was very adequate in all other situations, to take hold in the face of the illness of his brother, the student worker heard, "I can't believe my brother really has a mental illness. Will you want to see us, his relatives, to test our sanity? What *will* his wife and children do without him? Will his children be apt to inherit this illness? What will become of his business which he managed so efficiently until this happened?"

If we have eyes to see and ears to hear sensitively, we can recognize the economic and marital difficulties, the parent-child difficulties caused by the disruption of family life that mental illness means, and that, in turn, may lead to other problems within and without the immediate family of the patient. How these are dealt with can further or impede

the patient's return to health. He, too, is a part of these problems and may need to discuss them with the social worker when he is able.

Mrs. A., forty-years old, was admitted in a confused state to a small hospital devoted to study, treatment, research, and teaching, after spending five hours in a large mental hospital to which she had gone on the advice of the family doctor because of a psychotic episode after the birth of her ninth living child.

When she came to the second hospital, she was first noisy, hallucinated, then confused, anxious, and prayerful. She tried to harm herself. During the second week she was quiet and during the third week, much improved.

When seen by the student psychiatric social worker, who asked the nurse to introduce her, Mrs. A. was showing pictures of her children to another patient. She agreed that she would like to talk to the social worker alone. The social worker explained that she was there to help her with the problems that being ill and being in the hospital might have created for her.

Mrs. A. said that she missed the children; she had not seen the baby; and she did not know when she would be going home. She supposed that the doctor who sent her to the hospital would decide when she should leave. She looked questioningly at the social worker, who said that she could understand why Mrs. A. thought he might be the one to decide, but went on to say that the hospital doctors would decide because they were taking care of her now and would know how she was getting along. How did she feel about this?

Mrs. A. said that her husband had told her she was in the hospital to gain weight, but she would like to know what kind of hospital this was. She said she was told when she came in, but it was a long name and she did not know what it meant. The social worker explained that it was a hospital for nervous people. Mrs. A. seemed relieved that she would not have to stay for gain in weight. She said that she was nervous after the baby was born. She realized that she needed rest and that things would have to be different when she went home. She added that rearing nine children with few conveniences is a big job. She was concerned about how her husband was getting along running the house. Would the social worker talk with him? She was worried about her little girl's ear infection, too.

Mr. A. was fearful of his wife's illness, as one would expect from his telling her that she was there to gain weight. He had managed well for these few weeks, but wanted to plan for the future. His first thought was to have his wife go to her relatives against her wishes instead of returning home.

With the help of the social worker, who saw this plan as an expression of his fear of his wife's illness, he was able to discuss this and other plans more realistically after he had talked for an hour of his fear of his wife's former violence; his feeling that he was going to pieces, as he had never seen any one act like that; and his wish to spare her and himself from facing this illness.

After a helping process that progressed step by step and called for the use of knowledge of the illness, and of its meaning to him and to his

wife, but also for a professional relationship that enabled him to discuss freely the emotions that prevented him from helping his wife, he was able to say that he would choose to have his wife at home if the hospital social worker would help him and his wife to bring about a healthier social situation there.

The student worker continued to help both Mr. and Mrs. A. with social problems within and without the hospital while Mrs. A. was in the hospital. The psychiatrist and nurses worked with Mrs. A. in relation to her illness, giving her sick self the treatment necessary for a return to health. The psychiatric social worker helped Mrs. A. to bring about that "difference" which she knew must exist at home if she were to stay well. Mr. A. was enabled to enlist the services of a public-health nurse and of a family social worker, not only in obtaining a home-maker to serve his family, but for help with the broader problems of family life.

The student psychiatric social worker might have been more helpful to the family worker if she had shared her understanding of Mrs. A. and of the attitudes one could expect her to have toward the home-maker and others as a result of her illness. She did continue to give support to Mrs. A. during the convalescent period. The nurse and the social worker together enabled Mrs. A. to use private medical care for a physical condition.

Ryerson, in an article entitled *Social Case Work with Patients Treated with Shock Therapies,* writes:

"The direction of case work treatment with the post-schizophrenic patient is toward synthesis of the patient's personality, the aim being to aid, in whatever way possible, the repression of the conflicts precipitating the breakdown, a decrease in self-preoccupation, and the diversion of the patient's energies toward normal external interests.

"A typical case illustration is that of a young married woman who was hospitalized in an acute catatonic episode following the birth of her second child. She improved rapidly under a course of ambulatory insulin and E.C.T., losing her hallucinations, confusion, paranoid ideas, agitation, and depressive symptoms. She was discharged two months after the termination of E.C.T., the total hospitalization period being four months. After the usual reactions of confusion and memory loss began to clear following the termination of E.C.T., this patient received psychotherapy on a superficial level of encouragement and reassurance. At the same time, the social worker visited the patient three times weekly in the interest of developing a relationship that would be continued following the discharge of the patient, when she would no longer be seeing the doctor. The patient, although symptom-free, retained the shyness and reserve characteristic of her pre-psychotic personality. She stated that she wished to talk about the things that were worrying her, but was unable at first to verbalize them. She gradually became at ease with the worker, responded to the warmth and stimulation, showed renewed interest in reëstablishing her home and caring for her two small children. She was evasive about her illness, having an amnesia for the entire period of her acute episode. The treatment of the worker has been focused on giving help and support around the practical

realities of the patient's resuming her rôle as wife and mother, without attempting to explore more deeply into conflicts relating to the period of illness. The existence of a positive relationship with the worker and support around resuming life outside the hospital have been important factors in this patient's stabilization and adjustment following a relatively short period of hospitalization."

Recent research has shown that patients denied professional psychiatric social service return more frequently to the hospital.

To be clear about the rôle of the psychiatric social worker in the hospital, one must be clear about the distinction between the help that the psychiatrist gives with inner tensions and intrapsychic conflicts and the help that the social worker gives with social problems related to illness. Although the patient may discuss the same problems with both, both can be more helpful if they see the difference in their purpose and their focus. The social worker's task—no matter how much knowledge of psychiatry she has—is not that of bringing about total personality change (although in a modified way this may be a by-product of her help), but rather that of helping individuals with the reality difficulties they encounter in social situations. For the psychiatrist to confine his attention to social measures may lead to a disregard of the dynamic factors in a patient's illness, while for the social worker to attempt to deal with intrapsychic conflicts *per se* may divert her from her true function—that of helping patients and their relatives to work out a way of dealing with the social problems associated with the illness.

In closing, I should like to take this opportunity to congratulate Western State Psychiatric Institute and Clinic for bringing together at this conference members of the four professions of medicine, nursing, psychology, and social work, to share with one another their different, but related knowledge for the benefit of those residents of Pennsylvania and neighboring states who are mentally ill. In the past, it seems to me, we have often handicapped our own efforts by our separateness. The efforts of the psychiatrist, of the psychologist, and of the nurse may be almost wasted if the patient is not helped with his social problems; and, on the other hand, the efforts of the social worker are often futile with-

out adequate contributions from medicine, nursing, and psychology.

If we really see the patient as he moves through the total experience of this illness, do we not see his need for the related services of all these professions? At different points in his illness, we may flexibly need to take a major or a minor part. This conference, therefore, seems to be one way for us to become increasingly aware of one another's professional contribution.

This awareness, however, is only a first step. Can it not be followed by small round-table meetings in which we might work out ways and means of achieving a relatedness—of setting up an administrative structure within hospitals that would really achieve a fundamental working together, and of promoting community meetings in which we might have joint sessions, with the sharing of knowledge and discussion of ways and means of using it ever more effectively in our mutual endeavor in the care of the mentally ill?

This should add up to greater social contributions from those who have *had* a mental illness and thus to an increased social welfare for our total community now and in the future.

BOOK REVIEWS

TUTORING AS THERAPY. By Grace Arthur. New York: The Commonwealth Fund, 1946. 125 p.

This is a book that has long been needed to remind us that there are educational problems that should be treated by appropriate educational methods rather than by psychotherapy. Of late there has been a tendency to overlook this, for the discovery that reading disabilities or other scholastic failures are in many instances one of the symptoms of emotional disturbance or neurotic conflict has sometimes led to the false assumption that this must always be the situation whenever a bright child has trouble in learning. In reality, of course, there are just as many children — perhaps more — whose educational failures have been the stimulus for emotional reactions leading to behavior difficulties. If we had forgotten or doubted this fact, Dr. Arthur's report should correct our misapprehensions.

In her first chapter Dr. Arthur recalls an early experience, before the days of child guidance, when she did psychological and remedial educational work with pupils in kindergarten and first four grades of a school in St. Paul. After reading this chapter, the conclusion is unavoidable that if all schools could sponsor such work with children in the early grades, the number of educational maladjustments and behavior problems in the later grades would be very greatly reduced and there would be fewer children with these problems referred to child-guidance clinics.

It is the reviewer's conviction that neither counseling or psychiatric service in the schools nor the opportunity for referring children to clinics relieves the schools of the obligation to do effectively their primary job of educating the child. This function will not be fulfilled entirely, however, until more and better remedial teaching — or tutoring, as Dr. Arthur calls it — has been provided. It is to be hoped that educators will read Dr. Arthur's account of what can be accomplished by good psychological work combined with tutoring and that they will be influenced by what she has so ably demonstrated.

The second and third chapters of the book suggest how tutors can be found and trained, indicate the responsibilities assumed by the psychologist and the tutor respectively in their collaboration in any given case, describe the care with which a tutor should be selected for a particular child, and so on. There is no doubt that the success of the tutoring project undertaken by Dr. Arthur and her helpers was in large measure the result of her own exceptionally skillful work with the tutors, the parents, and the children. Fortunately, she has

given such a clear account of what she did and how she did it that her book can be used as a manual by other psychologists who are in a position to organize a similar tutoring service, whether in connection with a clinic or with a school.

Chapters four and five are concerned with some of the remedial teaching methods and with illustrative case summaries. The latter give some idea of the wide variety of situations, both as to types of educational maladjustment and the behavior problems associated with the educational difficulty, in which tutoring results in the kind of improvement in the child's social adjustment and behavior that we usually look for as a result of psychotherapy. Needless to say, improvement in school work also occurs—indeed, is basic to the behavioristic improvement.

In the last chapter, Dr. Arthur outlines a plan whereby communities could establish tutoring programs that would go far to meet the needs of the children. The results of her own tutoring project amply justify her concluding statement: "The cost of a tutoring program is insignificant compared with the cost of dealing with delinquent behavior that results when school maladjustment and failure to learn are ignored."

Besides emphasizing the necessity that this book be widely read and its lesson taken to heart, one should also state that reading it will be a pleasure, for Dr. Arthur's literary style is quite as outstanding as her competency as a psychologist.

PHYLLIS BLANCHARD.

Philadelphia Child Guidance Clinic

A POUND OF PREVENTION. HOW TEACHERS CAN MEET THE EMOTIONAL NEEDS OF YOUNG CHILDREN. By James L. Hymes, Jr. New York: Teachers Service Committee on the Emotional Needs of Children, Caroline Zachry Institute, 1947. 63 p.

First grades and nursery schools are now populated by the first crop of World War II babies. What proportion of them come minus fathers, or still scarcely knowing their living fathers, is a question. Their first teachers, whether of much experience or little, should be alerted to the almost universal emotional disturbances in these children traceable to the chaotic care and the anxiety-ridden persons with whom their first years of life were spent.

The purpose of this pamphlet is to draw attention sharply to the consequent behavior and the teacher's rôle in understanding and changing it. Thumb-nail case sketches are here. Not a single technical term or scrap of professional jargon mars the sixty-three pages. Humor blesses them in the form of comic-satiric drawings which have punch for those who can see behind the scenes.

The multitude of obstacles to good working conditions that beset most schools are not forgotten. Cramped rooms, deficient equipment, rigid rules, clerical demands, and interruptions, all drive the teacher to the breaking point of fatigue, irritability, or the blaming attitude. What the child needs in this new relationship is the exact opposite: fresh sensitivity to him as a person, friendly acceptance of his foibles, belief in his good intentions and wish to learn, patience with his mistakes, enough time to show him how to succeed.

The author uses both negative warnings and positive hints for social therapeutics. Samples: don't use everything children say or do to correct and improve them; don't hear every swear word; don't be a "shusher"; don't walk on "stilts"; don't nag eternally about the dirty hands, the smudge on the face.

Do reach out to them in friendly, appreciative, confidential conversation about their skills, possessions. Sit down on their own level; let them have a voice in decisions. The teacher needs to make herself real to children if she is to meet their needs.

One of the best sections is concerned with what growing up means in terms of giving up one's own wants, thereby piling up a burden of unexpressed angry feelings and frustrations. How provide safety valves to prevent explosions, to reduce inside pressures? A condensed inventory of practical methods is told excitingly, resourcefully.

The author does a good job of interpreting children's urgent feelings about hitting, bossing, destroying, messing, teasing. Crucial times for both child and teacher are described with insight.

An amazing territory is covered with few words. The style is sympathetically suggestive, not didactic.

One could wish that the author had not compared our psychologically scarred youngsters to Purple Heart wearers. Teachers, too, suffered terrific losses, shocks, amputation or malnutrition of the spirit during the war.

The reviewer feels a bit uneasy about the "pound" instead of "ounce" in the title. Minor flaws, however, do not seriously detract from a genuine work of art in the field of the mental hygiene of education.

MIRIAM C. GOULD.

New York City.

HELPING TEACHERS UNDERSTAND CHILDREN. By the Staff of the Division on Child Development and Teacher Personnel. Washington, D. C.: American Council on Education, 1945. 468 p.

This report of a group project was prepared for the Commission on Teacher Education. The consultants from the commission's staff were Fritz Redl, Caroline M. Tryon, and Daniel A. Prescott. Dr.

Tryon and Dr. Prescott, aided by Mrs. Helen K. Bieker, carried the responsibility for the final drafting of the report.

The purpose of the book is to demonstrate how individual classroom teachers and teaching principals gradually deepened their understanding of the causes that underlie the conduct of children, and how they increased their skill in identifying such causes in the case of particular children and groups. The method of demonstration chosen is that of supplying the reader with samplings of what these teachers wrote at different stages during the first three years of the program in child study in which they were participating.

The chapter headings suggest the nature of the report: I. *What It Means to "Understand" a Child;* II. *Learning to Describe Behavior;* III. *Seeing the Child as a Member of a Family;* IV. *Help from a Psychologist;* V. *Learning Some Explanatory Principles;* VI. *Group Meetings as a Study Method;* VII. *Looking for Patterns;* VIII. *Studying a Personality Through Time;* IX. *Studying the Interaction of Children in Groups;* XI. *Teachers and Administrators Evaluate the Study;* XII. *Conducting a Program of Child Study;* and XIII. *What Experience Has Taught Us.*

Local administrators and group leaders sought evaluations of the study from all participants toward the end of each school year. The administrators used the evaluations as a partial basis for deciding whether or not to continue the study, and the leaders used them as guides for planning next steps. The most important outcomes of the early period of the study program were: (1) the recognition that behavior is caused; (2) a developed interest in learning the causes that underlie the behavior of children in the classroom; (3) the realization that acquaintance with parents and home backgrounds and the direct observation of children are two of the best available sources of significant information; and (4) the fact that greater happiness in teaching accompanies this development of interest in understanding the individual child.

Classroom teachers, principals, and supervisors were remarkably unanimous in their evaluations on one matter. Nearly all of them reported either that they themselves were happier in their work because they understood the children better, or that the children were visibly happier in their classrooms than they had been before the study began. One of the most significant comments was: "The teacher herself doesn't seem to feel that behavior problems are things of which to be ashamed."

For many readers, the earlier chapters will be more understandable if Chapter XII, *Conducting a Program of Child Study,* is read first. Many questions that obtrude themselves during the reading of the earlier chapters are answered in this. At no point, however, is it

made entirely clear as to what clinic facilities were available to the schools participating in the study. Often in the teachers' notes opinions are given in regard to abilities or school achievement of children when specific data in quantitative terms, if available, should be presented to clarify the picture for the reader.

The lack of reference to clinical findings suggests that this is a study in the sympathetic understanding of children in their general social adjustment. The intellectual problems of the children discussed seem to have received little attention. One teacher volunteers, "It was wonderful to have our attention shifted from teaching techniques to child study." "Understanding" these children did not seem to include the understanding of *why* one little boy could not write; or *why* a twelve-year-old boy, "really the brightest boy in the room" (in the fourth grade!), had not learned like other twelve-year-olds; or *why* children distressed over their failure to learn could not be helped to learn instead of being encouraged to spend their school time in activities that might have been carried on without the help of a teacher.

Apparently, the most valuable result of the project lay in the emotional growth of the teachers. "They have learned or are in the process of learning not to think of behavior as good or bad, as normal or problem behavior, but as the active effort of a developing child to deal with life as he meets it. They are beginning to see that behavior is caused or evoked by situations interpreted by each child in the light of his own unique experience background."

GRACE ARTHUR.

Saint Paul, Minnesota.

OUR TEEN-AGE BOYS AND GIRLS. By Lester D. Crow and Alice Crow. New York: McGraw Hill Book Company, 1945. 366 p.

The problem of adjusting to the many changes that the child meets in the process of growing up has always been the hope and the despair of adults who, by the very nature of life, have been forced to remain on the side lines as helpless spectators, no matter how deeply involved and concerned they may be. To-day, children entering the adolescent stage are forced into a world in which the standards of behavior acceptable even five years ago are no longer suitable. Because we are now in one of those periods in the history of human development when the affairs of man are moving somewhat more rapidly than is customary, the need for guidance is even more urgent than usual, both on the part of young people entering the world of adult responsibility and also on the part of adults who

have already had adult responsibilities, including the guidance of youth, thrust upon them before they have solved their own inner conflicts.

Because of this recognized need for guidance during the teen-age years, much study has been directed to the problem. In the main, however, the readily available reference books are intended for the professional student of psychology, or else they are written down to the adolescent's own level, with the result that they sometimes sacrifice soundness of principle for vividness of presentation and in some cases overemphasize the lurid and the sensational. More often than not, the reader finishes one of these volumes with the feeling that he has been on a psychological slumming tour.

The present volume, it seems to me, has notably succeeded in presenting basic and sound principles which may be read with interest and profit by both counselors and teen-age youngsters. The material is presented in the form of brief illustrative case studies, given in sufficient detail so that the people described appear as actual individuals with problems rather than as disembodied illustrations. These case studies—along with the discussion materials with which each unit is introduced and the remedial suggestions with which it is concluded—should serve as a valuable aid to school counselors and other leaders of youth groups, many of whom are untrained in the specific field of guidance and psychological counseling.

The realistic and yet often humorous presentation of case material makes the volume one that can well be given to the adolescent himself for study. The fact that the teen-age youngster finds his own behavior mirrored in these cases can help him overcome the feeling of isolation that is frequently the main obstacle to therapeutic procedures. For the adolescent, the knowledge that he is not alone, that he is but one of many individuals who are having difficulty in finding their way, is reassuring. The cases described can help him understand that the process of advancing from childhood dependency to adult privileges can take place only if the individual is also willing to assume adult responsibilities, since these are intrinsically associated with the process of maturation.

The book is divided into units, each of which discusses one of the main areas in which the adolescent is forced to make an adjustment—home, school, vocational, and social life. Also included is a section on delinquency. The concluding section gives a brief statement as to what may be ahead for American youth.

This book should be valuable to the guidance worker and the counselor of youth, whether he be parent, minister, dean, teacher, or leader of various organized youth groups. It should also be

helpful as a source of enlightening information for the adolescent himself. Although the technically trained psychologist will find little that is new in it, it does present a fresh and realistic, yet hopeful, point of view.

ARTHUR L. RAUTMAN.

Carleton College, Northfield, Minnesota.

WHEN YOU MARRY. By Evelyn Millis DuVall and Reuben Hill. New York: Association Press, 1945. 450 p.

This new book on marital and family counseling has been brought out under excellent auspices. One of the authors, Mrs DuVall, is secretary of The National Conference on Family Relations; the other is a member of the Department of Sociology of Iowa State College. The book opens with a foreword by Ernest W. Burgess, of the University of Chicago, who says that it exemplifies "the functional approach to teaching marriage and family living. . . . The study of family relations as such has not been a very old one. It is a special focal point for bringing to bear various disciplines in sociology, psychology, psychiatry, and allied subjects on the subject of the relation of one man to one woman of the American family."

The authors then state that "getting married and raising a family to-day requires some advance preparation," which they offer herewith. Each author is married. Thus, a team of four authorities has pooled not only objective information, but a considerable wealth of personal experience and emotion. There is much good feeling in the book, as well as much objective data on which a sound teaching program for the subject of family living can be based.

The material is presented in the chronological order of a life history, beginning with a boy and girl who meet each other, become interested, have dates, indulge in courting, become engaged, get married, and then encounter the problems of a marriage. Money matters are particularly well handled; crises of all sorts are dealt with; divorce is discussed, and the question of just what it is that makes a husband and wife belong to each other in the sense of "family."

A section is devoted to babies, where they come from; parents and how they are developed; and the question of moral training of children and "religious living."

The last part of the book is philosophical; it defines the differences between marriage now and marriage as it used to be and projects the point of view of this quartette of thinkers on the subject of the family in the post-war period and in the future.

Each chapter is accompanied by a set of quiz questions, helpful

if the material is to be used for teaching. They clarify in the mind of the teacher or the student the chief concepts contained in each chapter.

On the whole, this is a consistent and well-written treatise. The writers beautifully elaborate the point that a growing, developing union between a man and a women is among mankind's most fruitful experiences. However, in one chapter called, *Morality Makes Sense,* they stumble around. They come out strongly for virginity before marriage and then monogamy, saying that in our society we insist on this conformity. But they also quote Terman's study, *Psychological Factors in Marital Happiness,* which clearly shows the sociological trend of our times away from virginity before marriage. In the groups Terman studied, such pre-marital virginity was rare among men, and was clung to in less than one-third of the women. At the same time the authors say "the code is monogamous marriage—one man for one woman—*at a time.*" The italics are mine. The authors themselves recognize here that even in our society there is some liberality in the marriage code.

The fact that religious beliefs foster monogamy and are opposed to pre-marital intercourse is mentioned, but that these are the only sound reasons for absolute monogamy is not adequately stressed. The authors fail to recognize a difference between pre-marital intercourse and promiscuity. There are important psychological reasons for avoiding promiscuity, but there are only religious reasons to be levied against pre-marital intercourse. Terman's study shows that cultural or social reasons no longer hold. The authors emphasize that sexuality without intimacy is a shallow, unrewarding experience, but they fail to recognize that a remarkably exciting and rewarding intimacy may develop in a shorter period than a lifetime.

On page 156, "an eminent psychiatrist" is quoted as saying that his practice is composed more and more largely of people who were promiscuous before marriage and who have, by implication, current sexual problems arising out of that fact. As a practicing psychiatrist, I would say that my practice is composed more and more largely of people who overvalue and hoard their virginity too long. Retaining virginity beyond the age of thirty builds a great hurdle in making a good sexual adjustment later.

It is far more difficult to relinquish psychological virginity in the more rigid thirties or later than it is to relinquish bodily virginity. Because of the fact that our society prolongs the training period of young people to a point where many men cannot support a family until after they are thirty, the problem of virginity at marriage becomes an extremely important one. Sexual patterns that are

inhibited too long are not easily uninhibited and soundly established. Sexual behavior is deeply rooted and is not subject to a great deal of modification in individuals beyond young manhood and womanhood.

This muddled thinking about the concept of morality is one of the things that make group marriage counseling, and all of the lecturing that social hygenists attempt to do in young people's meetings, so extremely difficult. I can understand why these authors did not express more liberality in their point of view in a book that they hope to sell widely. But a confused chapter of this sort weakens the whole structure of the book.

As opposed to this, the factors bearing on a good relationship between a man and a woman in sound and intimate marriage are extremely well set forth, clearly defined, and well documented. The "mental-hygiene" aspects of preparing for children and early child-raising are also very well handled. On the whole this is a thoughtful, well-written, and interesting book. It is useful reading and teaching material for every one engaged in counseling and guidance.

MARGARET C.-L. GILDEA.

Washington University School of Medicine, St. Louis, Missouri.

YOUTH, MARRIAGE, AND PARENTHOOD. By Lemo D. Rockwood and Mary E. N. Ford. New York: John Wiley and Sons, 1945. 298 p.

There is no area of education in which it is more appropriate and important to start with the student—his needs, abilities, and interests—than in the area of marriage education. In this area the "consumer" approach is a must. What the student already knows, his attitudes on various problems, the reasons for his behavior as he sees them, the standards that he has defined or has had defined for him, the influence of family and friends, the degree to which his behavior fits or deviates from the stereotypes of his day—all these and many other factors form the back-drop against which marriage preparation occurs. Marriage education will become more functional and more effective to the degree to which this back-drop is taken into account.

The book under review is a contribution to our understanding of college students' attitudes and reported practices relative to sex education, pre-marital sexual experience, marriage, parenthood, divorce, and similar items. It affords many provocative insights. Any one interested in college students, and especially any one interested in marriage education, may read this book with profit and might well have a copy on hand for reference. Some of the

findings may not be entirely new to him; but in research it is often as important to verify the suspected as it is to repudiate the accepted or to establish the new.

The book is the outgrowth of a questionnaire study of 364 college students. As such it is subject to the limitations of the questionnaire method; but the authors have been careful and thorough, and have presented their materials in interesting, readable form. One extremely useful device is a tabular comparison of the results of this study with those of similar studies, so that, although the reader may not have read these other reports and may be unable to obtain them, he may still get some of their high points and thus sharpen his appraisal of the present study.

It is, of course, not the fault of Drs. Rockwood and Ford that World War II interposed itself between the gathering and the publication of their data. Nevertheless, without knowing precisely what effect the war has had upon young people of college age and upon the personal and societal factors that play upon their behavior, we may safely surmise that the effect has been profound, that "things aren't what they used to be" and probably will never again be what they were prior to the war. This suggests two things: first, that in interpreting the data presented by Drs. Rockwood and Ford, the reader be careful not to assume, without adequate reason to do so, that the post-war student is an exact replica of the pre-war student; second, that there is need for continued research in this area.

HENRY BOWMAN.

Stephens College, Columbia, Mississippi.

FAMILIES IN TROUBLE. By Earl Lomon Koos. New York: Kings Crown Press, 1946. 156 p.

Although it is notorious that all families have troubles, this publication summarizes the results of a two-year study of 62 troubled low-income families, living in drab tenements, on both sides of the street of one block in the East Seventies of New York City, an area in which about one-third of the population is foreign-born of varied nationality backgrounds.

These families, about 61 per cent Catholic, with one or more children, were organized on the patriarchal pattern, with about 70 per cent of the fathers classified as laborers and the majority earning from $22.50 to $32.50 a week. Only six mothers were employed outside the home, average monthly rents were less than $30, and the families were exposed to more or less chronic worries in the struggle to keep afloat in a "hand-to-mouth," "nip-and-tuck" urban existence. The difficulties classified as "troubles" were those unex-

pected events which sharpened the usual sense of insecurity, blocked routine patterns of action, and required the facing and handling of new situations. Nearly one-fourth of the families studied had no troubles, and 46 families experienced 109 troubles during the study period.

Sixty-two of the 109 troubles involved financial or interpersonal problems resulting from death and acute or chronic illness, including one case each of mental illness and alcoholism and five unwanted pregnancies. In 18 instances, the troubles were due to poor management and indebtedness. Conflicts and sexual incompatibility between husband and wife accounted for 14 troubles, parent-child conflicts for six, and conflicts with neighbors for three. The addition of a grandparent to the family, an educational problem, and unemployment were encountered once each, and two resulted from the international situation.

Troubles were more frequent, disabling, and prolonged in the less-well-organized families, in which members did not "pull together" for the welfare of the family as a unit. Lack of money to meet emergency needs was a factor in 42 situations. The excessive cost of "good funerals," ranging from $280 to $450, was a great burden for these economically border-line families. Three-fourths of the troubles resulted in some lasting damage to the interaction of the family.

All the above troubles are briefly illustrated by graphic quotations of the persons involved. The book does not include full case records of any of the families studied.

In a city in which almost every known type of social-welfare assistance is available, a surprisingly small number of families used these resources. All 62 families knew of, and 57 had used at least once, the health agencies serving the area. Only 12 out of 43 families, aware of public-health-nursing services, had used them. Only five of 27 families, aware of family-service agencies, had sought their help. Day care for children, Legal Aid, and non-profit loan agencies were among the least known facilities. The resources to which these families first turned for advice in 57 emergency situations were, in order of frequency, relatives, the neighborhood druggist, a bartender, a priest, labor and political leaders, clergymen, and policemen. Only five out of 62 families had turned to a social agency for help.

Among the factors that weakened the adequacy of families to withstand troubles were conflicts over their economic status and the handling of money, the uneven cultural assimilation of foreign-born parents, cultural disparities between life in the home and outside, differences over the religious or social life of the family, parental conflicts over children or too close a tie with the previous genera-

tion, conflicts resulting from the sexual maladjustment of parents, adolescent sexual behavior, and residuals of past troubles and inadequacies. Fear of pregnancy was frequent, but only three families had had competent contraceptive advice. It was evident that more than half the children engaged in sex practices before the age of sixteen, but the needs of children for sex education and training for family life were ignored.

The author feels that the great values inherent in family life are being neglected, if not undermined, in our culture, and that far more thought, care, education, and protection are needed if these assets are to be preserved. Wider publicity and interpretation of available social services and easier accessibility seem needed, together with a more humanized approach to family problems and needs. It is undoubtedly extremely hard for families to have to go to highly specialized, widely separated social agencies for each particular service that may be needed in the family unit.

The study again underlines the fact that health is of basic importance in any population, and that health problems are one of the major factors in all social problems. In an era of high prices, the families studied certainly deserve social recognition for performing a major miracle in being self-supporting on their meager incomes.

The book is a very neat Ph.D. type of study, with considerable exposition of definitions and research techniques. It will probably be considered a greater contribution in academic circles, because of its emphasis on getting down to the grass roots of first-hand contacts with human beings and their problems. It has little psychiatric content, and while useful and suggestive, it may not be of great interest to workers in the mental-hygiene field.

CLARA BASSETT.

New York City.

THE FAMILY, FROM INSTITUTION TO COMPANIONSHIP. By Ernest W. Burgess and Harvey J. Locke. New York: American Book Company, 1945. 800 p.

This book, designed as a text for college classes on the family, achieves its purpose with distinction. It is authoritative and comprehensive, and the teacher who uses it will not have to apologize for the content. The scientific, detached, and balanced viewpoint of the authors, and their lack of bias, make possible an excellent distribution of emphasis.

The central thesis of the volume is that "the family in historical times has been, and at present is, in transition from an institution to a companionship." In the past, the family was held together by

external, formal, and authoritarian factors like law, tradition, authority of the family head, discipline, and ritual. At present, the family depends for its unity upon the affection and companionship of its members. The evolution of the family is sketched in Part I through a series of chapters devoted to types of family organization—primitive, Chinese, modern urban and rural, Negro, and Russian.

The foregoing theory of the evolution of the family, when elaborated, seems to be fully substantiated by the evidence from history and ethnology, but the abbreviated statement of the theory—viz., the family, from institution to companionship—presents a problem in semantics. The antithesis, "from institution to companionship," implies that the family was once an institution, but is not one now—that the companionship on which the family now rests is not conventionalized. Obviously this is not the case, for socially unsanctioned and unregulated sexual companionship is not marriage; it is evidence of the disorganization of marriage.

What the theory of family evolution actually describes is a shift from a type of family in the earlier agricultural economy, possessing numerous economic and correlated functions, to the modern industrial family which is organized more largely around the affectual relations of husband and wife and parents and children. It is incorrect to refer to the family of the past as "the institutional family" and to the modern family as "the affectional family," since the affectional functions are also institutionalized. Since the contrast is between the organization of the traditional family around economic functions, and the modern family around psychological ones, perhaps a title such as *The Family, from Economic to Social-Psychological Institution* would be more accurate, with the qualification in mind that the shift is one of degree and not an absolute change.

The modern small-family system emphasizes the special importance of personality development and interpersonal relations in family life. Personality development, to which Part II of the book is devoted, is viewed as the product of three sets of factors—genic, psychogenic, and cultural. There are chapters that treat the topics of culture, psychogenic conditioning, social rôles, and wishes. The treatment is thorough and systematic. Indeed a common criticism of such treatment is that it is not confined to high-lighting the family's contribution to personality, but includes much general material with which the reader who has taken courses in sociology and psychology may already be familiar.

Part III will also be of special interest to readers of MENTAL HYGIENE, since it deals with the topics of love and courtship, mate selection, marital adjustment, and predicting success in marriage. The last two topics in particular are handled with considerable

expertness and are calculated to advance existing knowledge of the subjects involved. Marital success is considered from eight standpoints: permanence of the union, happiness of the marriage, social expectations, personality development, companionship, satisfaction, integration, and adjustment.

This use of eight criteria in measuring marital success emphasizes the complexity of the problem of evaluating a marriage, which may rate high in some respects and low in others. It is not certain, however, that the above criteria are entirely distinct and separate factors, and it does not seem likely that all of them are. Except for the two factors, happiness and satisfaction, the criteria have yet to be put to actual scientific test and are for the present merely suggestions for future investigation and application.

This book sets a high level of excellence for texts on the family.

M. F. Nimkoff.

Bucknell University, Lewisburg, Pennsylvania.

Education for Modern Man. By Sidney Hook. New York: The Dial Press, 1946. 237 p.

One field in particular in which modern mental hygiene has yielded good fruit has been the education of the very young. Mindful of individual differences, avoiding needless conflicts, starting hobbies that may fill a lifetime, stimulating self-confidence by supplying tasks that enlist whole-hearted energies—this way of educating has already demonstrated its usefulness. Now the need to enrich it and to apply it at all stages of living, including the adult, is more urgent than ever. Enlightenment on this head is the purpose of these incisive chapters.

They were written by the young, but already distinguished, chairman of the department of philosophy in New York University. An ardent disciple of John Dewey, he has never thought of his own specialty as mainly academic. All genuine education, he has learned, is a matter of partaking in important experiences and reconstructing these in the light of the best possible reflections. Since that is a lifelong process, always immensely consequential to individuals and their society, a philosopher with such an outlook has much to tell us about the needs of our times and about how education, thus broadly conceived, can meet them.

"Education is everybody's business." But much of it after the kindergarten years, Dr. Hook holds, is deplorable. (He might have added that there are states in America in which kindergartens are still thought of as "fads and frills," not to be supported out of public taxes.) If his charge seems too sweeping, one need only recall how wide are the areas in which the ABC's of social science

or even of hygiene are still not applied or even known. What about the plea that education cannot change society, but merely voices the beliefs of the social order in which it is permitted to operate? Dr. Hook points out that this is true only in a society politically undemocratic. A free society will encourage self-criticism. Nor can schools alone rebuild a society; changes in economy, technology, political practices, and so on, all play their part. What education in a free order will do is to prepare the necessary attitudes and ideals—chiefly, that is, by offering experiences that make for growth in "reasonableness, free inquiry, and devotion to shared human values."

> "Educators, like all other citizens, cannot avoid taking a position on the central issues on which men divide. But their task as educators is not to preach any solutions they hold as citizens. Their duty is so to teach that, on the appropriate levels, students become aware of the central issues of their culture, habituated to scientific inquiry into the consequences of proposed solutions, sensitive to the values involved in these solutions and affected by them, and courageous in accepting the conclusions to which method and insight lead" (p. 66).

Democracy "presupposes that the electorate will be able to make intelligent decisions on the issues before it." Where will the motive power be supplied? It will not, in spite of the advocates of "released time" for religious instruction to-day, call for the specific teaching of religion. "A truly religious education is found wherever knowledge is so taught that it heightens the sense of human responsibility for the inescapable decisions which men must make." This is "moral" education in its broadest sense.

Implications for mental hygiene are abundant, even though they are not the author's main object. He writes as a philosopher concerned with the educational program that he thinks a democratic society requires most. On many grounds he rejects, for instance, to-day's plea for a return to the study of classical literature. Not the least important reason is the fact that minds differ and that a schooling that may promote a worthy growth in one person will retard it in another. The Hutchins-Adler-Barr school, in wanting all college students to take the same curriculum, is eager to see widely shared what it regards as best. It is as mistaken, however, as a doctor would be if, in his desire to promote public health, he prescribed the same exercise, the same food, the same medication, for everybody. Instead, give every person the best education from which experience shows that this person is likely to benefit himself and society most. Not all people serve in the same way.

The best results come when the true needs of the person to be educated become intelligently felt needs. Here the case for modern progressive education finds another strong support. It is under

attack to-day, in part because some progressive schools have failed to do their own job wisely, in part because the fears aroused in war time and its aftermath have led to an uncritical demand for military discipline. Elsewhere, it is to be hoped, the author will turn his gift of keen criticism to the claim that military training is the best way to develop "character."

Another threat to democracy lies in the plea for a vocational education that may be nothing more than job-training. Special training for the earning of a living is of course highly important. The danger is that many a "vocational" program today "tends to make the job-trained individual conscious only of his technological responsibilities, but not of his social and moral responsibilities."

> "He becomes a specialist in 'means,' but indifferent to 'ends' which are considered the province of another specialist. The main concern is with 'getting a job' and after that with 'doing a job,' no matter what the political direction and moral implications of the job are. Social programs are judged simply by whether they promise to provide the jobs for which the technician is trained. If a democratic community can supply the opportunity for work, well and good; if it can't, and a totalitarian party or government offers the opportunity, why not? The problems on the job are applications of scientific knowledge in contexts of social values and human relationships. And it is these which conventional vocational education persistently ignores" (p. 157).

> "The aim should be to relate liberal and vocational education in such a way that no matter how a man earns his living he will not lose sight of the communal traditions to which he owes his knowledge and skills, the communal responsibilities he shares with his fellows, and the communal tasks to which he can make his distinctive contribution. Vocational education which fails to do this is illiberal and had best be abandoned" (p. 168).

The concluding chapter, *The Good Teacher*, evidently has in mind the instructor in college. But many of the things said there are as true for teachers of younger pupils. Promising potentialities can be neglected because some teachers are not interested in getting them cultivated. Poor teaching—*e.g.*, failure to secure live participation in projects or discussions by other pupils in addition to the few superior ones—is responsible for many needless aversions or conflicts. The good instructor will "make as many as possible see as much as possible of what they have not seen before."

Dr. Hook is not thinking only of, let us say, botany. He wants younger and older people to capture over and again unceasingly visions of a nobler social order, and to use the instruments of democratic living to promote the tasks thus indicated. Hence he is at all times insistent upon the therapeutic value of free inquiry. Communities that have not yet seen this light might well ponder

Dr. Hook's reminder: "A democracy is the only society which in principle believes that men can accept the truth in every realm of thought, and live with it."

HENRY NEUMANN.

Ethical Culture Society,
Brooklyn, New York.

MAN, MORALS AND SOCIETY. By J. C. Flugel. New York: International Universities Press, 1945. 328 p.

In 1921, Professor Flugel published *The Psychoanalytic Study of the Family,* which to-day remains one of the best books on this subject. In it the author, one of the earliest British psychoanalysts, examines with great accuracy and interpretative originality the psychoanalytic factors that enter into family tendencies, and—especially in the latter part of the book—devotes much attention to family influences in the development of the social adaptation of the individual within the family—the nature of his love life and social attitudes and the practical aspects of love and hate in ethical and moral problems in the community at large. This previous study may be regarded as a foundation for the present book, which reflects the author's own growth and his evaluation of the contribution of psychology and psychoanalysis to the understanding of social trends during the ensuing twenty-five years.

Deeply impressed by the failures of men in the past and present to solve social problems satisfactorily, Flugel hopes, none too sanguinely, that solutions may some day be achieved by investigation and understanding of the psychological forces that produce the problems, and advocates the substitution of judgment based upon psychological insight for moral judgment.

In applying the psychological point of view to the field of politics and government, Flugel continues to adhere closely to most of the original theories of Freud and his followers, but gives discerning consideration to other psychoanalytically based approaches and to non-analytical psychologists and sociologists, such as McDougall, Piaget, and J. M. Baldwin.

Because the state is both a father and a mother symbol, Flugel traces in detail the origin and function of the ego ideal, the conflicts that arise within the ego, and some of the methods by which a person attempts to solve them. This may be done by sacrificing his potential self, by compensations and protests, by restrictions of the ego, and so on.

All of these personal difficulties find their counterparts in the conflicts that affect nationalistic and internationalistic strivings and demands. Of course, the inherent aggressiveness of the human being

finds submission to parental or father authority extremely difficult, so that the origins of infantile aggression and their continuation in altered forms later in life are of paramount importance. Here Flugel gives a sympathetic estimate of Melanie Klein's views on this topic, which have received little attention in this country, and falls just short of actually endorsing them.

According to Klein's theory, the child's impulses up to the age of two or three months are at an aggressive-ambivalent stage and are intensely crude and cruel. The infant fears that all sources of relief for his internal tensions may be removed forever and projects this violent hostility upon his mother, but subsequently introjects this concept. Here is the source of the severity of the super-ego. The transition from this early antagonistic view that the child has of its parent to a mild and more benign one occurs slowly and much later. The child then develops the need for reparation, which may become genuine, and the denial by society of such needs, which are closely associated with the feeling of being needed, is productive of great moral and sociological harm.

In his final chapter, Flugel presents brilliantly and authoritatively the psychoanalytic psychology (mechanisms) underlying such problems as the right and the left in social attitudes, discipline in education, patriotism, cosmopolitanism and class distinctions, religion, war and peace. Simple solutions of these questions, which now as in the past confront a turbulent world, cannot be expected. When it comes to suggestions for the alleviation of the clashes in each of these fields, the author has little more to offer than the moral equivalents of war that William James advanced half a century ago. Flugel rephrases this in somewhat different terms—namely, that "the joy of coöperation in a larger purpose must be preserved if we are to find a peaceful 'equivalent' for war." Hitherto, "the brotherhood in arms has been the supreme form of coöperation," and up to now men have "hardly begun to realize that Progress can be an ideal embracing and inspiring to mankind." The difficulty of transforming "much that is primitive and sinister in human nature" into the service of such an ideal has not escaped the author, but does not entirely discourage his hopes for the future.

The level of thinking and the dignified style of presentation in this book require and merit close attention from the reader, as well as considerable familiarity with psychoanalytic concepts. However, be the reader sociologist, philosopher, psychologist, or clinical psychoanalyst, he will be richly rewarded for his effort and will return to this source book in years to come for light and inspiration on questions of human relationships in their wider aspects.

C. P. Oberndorf.

New York City.

GROUP PSYCHOTHERAPY, A SYMPOSIUM. Edited by J. L. Moreno. New York: Beacon House, 1945. 305 p.

This book contains a number of contributions on group psychotherapy. The first chapter deals with the 1932 conference on the application of the group method in the treatment of prisoners. The plan had been formulated by Dr. Moreno and was presented before a group of outstanding psychiatrists, criminologists, and penologists which included William A. White, Franz Alexander, V. C. Branham, and others. The plan advocated a dynamic adjustment of the inmates of the prison community "through techniques of reorganization, assignment, retraining, and other methods of group manipulation," so as to find for each one the most desirable place. Unfortunately, no information is given in this chapter regarding the fate of the plan discussed at that meeting.

In the next chapter, some of the papers presented at the round-table discussion conducted during the 1944 meeting of the American Psychiatric Association are recapitulated. Group psychotherapy as it has been practiced in the navy is discussed by F. J. Braceland. An account of the method as it has been employed with veterans is given by Samuel B. Hadden. The application of visual aids in preventive group psychotherapy with soldiers is presented by R. R. Cohen, and others. There are papers by J. H. Pratt and A. A. Low representative of the lecture method, and accounts by E. W. Lazell, Louis Wender, and N. Ackerman, on the analytic method. The application of motion pictures to group therapy is discussed by H. P. Rome, and the utilization of music and the dance by M. H. Ward and Marian Chace, respectively.

Psychodrama, as practiced in various institutions, is heavily represented in the book. The vast program of group psychotherapy as practiced in the army treatment centers, both in general and in convalescent hospitals, during the war finds virtually no representation. The absence of an account of the valuable work done with children by Lauretta Bender and others is also regrettable.

The subject matter in the book has not been correlated and the historical review of group psychotherapy is very sketchy. The material presented in the various papers is, however, valuable as a reference source. Bringing together in one volume the stimulating views of many proponents of group psychotherapy, the book constitutes a worth-while addition to the library of the student of group psychotherapy.

SAMUEL PASTER.

Kennedy General Hospital,
Memphis, Tennessee.

NOTES AND COMMENTS

The Lasker Award for 1947

Announcement has been made by Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene, that the committee in charge of the Lasker Award in Mental Hygiene has decided to present the award this year for a significant contribution in the field of popular adult education, with special reference to parent-child relationships.

The Lasker Award in Mental Hygiene, established in 1944 by the Albert and Mary Lasker Foundation, is an award of $1,000 presented annually for outstanding service in some field of mental hygiene. It has been presented three times: in 1944 to Colonel William C. Menninger, M.C., Chief Consultant in Neuropsychiatry, Office of the Surgeon General, U. S. Army, for his outstanding contribution to the mental health of the men and women in the armed forces; in 1945 to Dr. John Rawlings Rees, Consultant in Psychiatry to the Directorate of Psychiatry of the British Army, and to Major General G. Brock Chisholm, Deputy Minister of National Health, Federal Department of National Health and Welfare, Canada, for their work in the field of rehabilitation; and in 1946 to Dr. W. Horsley Gantt, head of the Pavlovian Laboratory at Johns Hopkins University, for his significant experimental investigation into behavior deviation, and jointly to Dr. R. B. Sharpe, of the Cleveland Baptist Association and Mr. Walter Lerch, of the *Cleveland Press*, for their outstanding contribution to the advancement and improvement of public mental hospitals.

Presentation of the award will be made, as usual, at the annual meeting of The National Committee for Mental Hygiene, on November 13. Nomination of candidates for the 1947 award should be submitted by September 10, with full supporting data in triplicate, to Dr. George S. Stevenson, The National Committee for Mental Hygiene, 1790 Broadway, New York 19, N. Y.

American Association of Psychiatric Clinics for Children

For a number of years the Division of Community Clinics of The National Committee for Mental Hygiene had annually sponsored informal gatherings of child-guidance-clinic directors. In February, 1944, in Chicago, the directors present, recognizing the need for a national association of community clinics that serve children, constituted themselves an initiating group to develop such an organization. The next year their plans crystallized further, and Dr. Frederick H.

Allen, of Philadelphia, became the first president of the American Association of Psychiatric Clinics for Children. Invitations to join the association were sent out, and there are now thirty-seven active and six associate members.

The purposes of the association are: (1) to provide for a closer coördination of the activities of psychiatric clinics serving children in the United States and its territories; (2) to establish and maintain standards and improve clinic practice; (3) to create standards for membership in this organization and to develop a creditable and acceptable structure for further development of psychiatric clinics serving children; (4) to provide opportunity for the exchange of ideas and the study of administrative problems by means of conferences, and the gathering and distribution of information about clinics, their policies and procedures; (5) to evaluate at regularly stated intervals the work of the member clinics in order that the services of all may be improved; (6) to promote the training of clinic personnel; (7) to collect biographical data on psychiatrists, psychologists, and psychiatric social workers as an aid to placement and professional advancement; (8) to carry on such other activities as will advance the field of child psychiatry.

The officers of the association for 1947 are: President, Dr. Frederick H. Allen, Philadelphia; Vice President, Dr. Audrey Sims Schumacher, Cleveland; Treasurer, Dr. Harry M. Little, Pittsburgh; Secretary, Ruth Mellor, Louisville.

The association is an independent organization, acting in an advisory capacity to The National Committee for Mental Hygiene, which furnishes the association with administrative assistance through its Division on Community Clinics.

Dr. A. Barhash to Head Division on Community Clinics

The National Committee for Mental Hygiene has appointed Dr. Abraham Z. Barhash, of Newark, New Jersey, as Director of its Division on Community Clinics. Dr. Barhash will succed Dr. Milton E. Kirkpatrick, who has combined this work with his position as Director of the Guidance Center, New Orleans, Louisiana.

A former Commonwealth fellow in child psychiatry, Dr. Barhash has served as psychiatric consultant at the Wilkes-Barre (Pennsylvania) Children's Center and the Rochester (New York) Guidance Center, and as Director of Clinics of the New York City Committee on Mental Hygiene, a demonstration project with a variety of clinics, such as evening mental-health clinics in city hospitals, a teaching experiment at the Astoria Health Center, and a clinic for adolescents.

Dr. Barhash returned recently from four years' service in the army, including one year as psychiatrist in the neuropsychiatric section of

the Fort Dix (New Jersey) Station Hospital, and three years as Chief of Section at Mason General Hospital, Brentwood, New York.

The Division on Community Clinics, which heretofore has operated chiefly in the field of child psychiatry, is planning to expand its functions to include adults as well as children. In this way it can help communities to plan clinics under the National Mental Health Act passed by Congress last July.

Dr. Burling to Direct Research in Vocational Rehabilitation of Psychiatric Casualties

Dr. Temple Burling, who for several years has been Medical Director of the Providence (Rhode Island) Child Guidance Clinic, has joined the staff of the Division on Rehabilitation of The National Committee for Mental Hygiene.

After serving as resident physician at the Sheppard and Enoch Pratt Hospital, Baltimore, Dr. Burling became psychiatrist at the Institute for Juvenile Research, Chicago, in 1931. He has been psychiatrist of the Winnetka, Illinois, Public Schools; has acted as assistant professor of mental hygiene at the University of Illinois Medical School; and has been psychiatrist for R. H. Macy and Company, New York.

At The National Committee for Mental Hygiene, Dr. Burling will participate with the division's staff in making a study of the vocational rehabilitation of the mentally and psychologically handicapped. He will work in close coöperation with the Federal Bureau of Vocational Rehabilitation and some of the state bureaus.

Besides making individual case studies, Dr. Burling and his assistants will assemble information regarding the experience of agencies and institutions in the rehabilitation of the mentally handicapped, and will develop a system of vocational rehabilitation, which will include psychiatric treatment and specialized training, if indicated, as well as consultation in placement. A survey of available resources for psychiatric treatment, social service, and vocational training will also be made.

The project will be carried on in communities of various types, such as a large city, small urban centers, and rural areas.

National Health Council Names Bailey B. Burritt as Executive Director

The National Health Council has announced the appointment of Bailey B. Burritt, long a leader in the health field, as its executive director. Mr. Burritt will launch a program of more active leadership among the twenty national voluntary health agencies represented on the council. The basic aims of the new program are more effective

prevention of sickness and maintenance of health among the people of the United States.

An appropriation of $78,500 by the Rockefeller Foundation has made possible the expansion of the council's national-health program.

Mr. Burritt, the new executive director, was, from 1914 to 1939, general director of the New York Association for Improving the Condition of the Poor, and from 1939 to 1944, senior executive director of the Community Service Society of New York.

Retiring in 1944, Mr. Burritt has continued many important activities in behalf of health organizations. He was president of Neighborhood Health Development, Inc., for more than a decade. He is now president of the New York Tuberculosis and Health Association; chairman of the Executive Committee of the American Social Hygiene Association; a member of the Board of Directors of the Community Service Society, of the Judson Health Centre, and of the National Tuberculosis Association; and a member of the Health Advisory Council of the United States Chamber of Commerce.

The National Health Council, which began to function in 1921, consists of representatives from such major organizations as The National Committee for Mental Hygiene, the National Tuberculosis Association, the American Social Hygiene Association, the American Cancer Society, the American Heart Association, the American Public Health Association, the American Red Cross, the National Organization for Public Health Nursing, and the National Safety Council. It has headquarters at 1790 Broadway, New York City, where it maintains a number of services that are available to all health agencies.

Besides working as a unifying and coördinating agency among national health organizations, the National Health Council coöperates with state and local groups in their efforts to improve health services. One of the aims of the expanded program is to make a qualified field service available to states and cities in which the problem of coördination among voluntary health agencies is urgent. Plans are also being made to expand the health-education services available to member agencies of the council.

Twenty-fourth Annual Meeting of the American Orthopsychiatric Association

Over eight hundred people, including both members and non-members, attended the Twenty-Fourth Annual Meeting of the American Orthopsychiatric Association, which was held at Cincinnati, Ohio, February 17-19. A wide range of subjects was covered in the various sessions and round-table discussions that made up the three-day program. They included "The Scientist in Society," "Education and Psychotherapy of Infants and Pre-school Children," "Psychiatry in

Postgraduate and Undergraduate Medical Education," "Studies in Human Sex Behavior," "Psychological Aspects of Orthopsychiatry," "Pediatrics and Psychiatry," "Psychological Aspects of Minority Problems," "Problems of Child Guidance Services in Semi-rural and Neglected Areas," and "Culture and Psychopathology." One session was devoted to "Social Work and Social Agencies," and two to "Clinical Studies," and a symposium, open to members only, was held on "Adolescence: Normal Development and Problems."

There were two luncheon meetings, at one of which Dr. Daniel Blain, Medical Director of the Neuropsychiatric Service, Veterans Administration, spoke on "Progress and Problems of Neuropsychiatry in the Veterans Administration"; while at the other Dr. Robert H. Felix, Medical Director of the Division of Mental Hygiene, United States Public Health Service, discussed the National Mental Health Act. At the annual dinner meeting, the outgoing president of the association, Dr. S. Spafford Ackerly, professor of psychiatry at the University of Louisville School of Medicine and Director of the Louisville Mental Hygiene Clinic, delivered the Presidential Address

The officers elected for the coming year are: President, Milton E. Kirkpatrick, M.D., Director, the Guidance Clinic, New Orleans, Louisiana; Vice President, Marian McBee, Executive Secretary, New York City Committee on Mental Hygiene; Secretary, Nina Ridenour, Ph.D., Assistant Executive Secretary, New York City Committee on Mental Hygiene; Treasurer, James M. Cunningham, M.D., Director, Bureau of Mental Hygiene, Department of Health, Hartford, Connecticut; President-elect, S. J. Beck, Ph.D., head of the Psychological Laboratory of Michael Reese Hospital, Chicago.

The association has decided to meet hereafter in April instead of February. Its next meeting—the Twenty-fifth Anniversary Meeting—will, therefore, be held April 12-14, 1948, in New York City.

Fourth Annual Conference of the American Group Therapy Association

The Fourth Annual Conference of the American Group Therapy Association was held in New York City, January 10 and 11. The program opened with an evening session in which Jessie Edna Crampton, Marjorie Holden, and A. A. Fabian, M. D., of the Brooklyn Child Guidance Center, described an experimental project in the parallel group treatment of pre-school children and their mothers.

There were two sessions on the following day, one on "Research and Training in Group Therapy" and the other on "Group Psychotherapy in Private Practice." The three papers presented at the first were *Observations on Emotional Currents in Interview Group Therapy with Adolescent Girls,* by Hyman Spotnitz, M. D., of the Jewish Board

of Guardians, New York City; *The Effect of Activity Group Therapy on Sibling Rivalry*, by Mildred Becker, of the Hawthorne-Cedar Knolls School, Hawthorne, New York; and *Experience in and Plans for Training of Group Therapists*, by S. R. Slavson, of the Jewish Board of Guardians. At the second session, Nathan W. Ackerman, M. D., instructor in psychiatry at the College of Physicians and Surgeons, Columbia University, reported on an experiment in the treatment of adolescent boys and girls in which interview group thereapy was used as the sole technique; Abraham A. Low, M. D., associate professor of psychiatry at the University of Illinois Medical School, Chicago, spoke on "Private Psychiatric Practice Based on Group Therapy"; and a joint paper on the use of group therapy in the treatment of allergy patients was presented by Hyman Miller, M. D., assistant professor of clinical medicine, University of Southern California, Los Angeles, and Dorothy W. Baruch, Ph.D., consulting psychologist, Los Angeles.

The chairmen of the three sessions were, respectively, Temple Burling, M. D., of the Providence (Rhode Island) Child Guidance Clinic; Robert A. Young, of the Judge Baker Guidance Center, Boston; and Lawson G. Lowrey, M. D., assistant professor of clinical psychiatry, Columbia University. Among the discussants of the various papers were George E. Gardner, M. D., of the Judge Baker Guidance Center; John C. Thurrott, M. D., of the New York School of Social Work, Columbia University; Nolan D. C. Lewis, M. D., of the New York State Psychiatric Institute and Hospital; Viola W. Bernard, M. D., of the Vanderbilt Clinic, New York; Wilfred C. Hulse, M. D., of the Long Island College of Medicine, Brooklyn; and Samuel B. Hadden, M. D., of the Presbyterian Hospital, Philadelphia.

Homer Folks Retires

Homer Folks has resigned from the New York State Charities Aid Association after more than half a century of service, continuous except during a term of office as Commissioner of Public Charities of New York City and periods abroad with the American Red Cross during and immediately after the first World War. On January 31 he completed fifty-four years as secretary of the association, having assumed that office on February 1, 1893, twenty-one years after the founding of the association by Miss Louisa Lee Schuyler.

Mr. Folks was born in Hanover, Jackson County, Michigan, February 18, 1867. Graduating from Albion College in 1889, and from Harvard in 1890, he became General Superintendent of the Children's Aid Society of Pennsylvania on August 1 of that year and held the position until he came to the State Charities Aid Association in 1893. He was one of the first university men to choose social work as a career.

In 1907, on Mr. Folks' recommendation, the State Charities Aid

Association began a movement with the state health department and other agencies for the prevention of tuberculosis in the state of New York outside of New York City. Mr. Folks helped to direct the organization of what rapidly became, in the judgment of competent observers, the most comprehensive and successful state campaign in this country for preventing tuberculosis. It resulted in the enactment of a number of important statutes, the establishment of a series of county tuberculosis hospitals and clinics, and the employment of a large number of public-health nurses. Since 1907, the tuberculosis death rate in up-state New York has declined from 152.8 per 100,000 population to 32.8 in 1945, a reduction of 78.5 per cent.

A very important by-product of this campaign was the appointment by the governor, in 1913, of a special public-health commission to recommend a revision of the public-health law. Mr. Folks was secretary of this commission, which successfully urged the passage of a new public-health law for this state, important features of which have since been enacted in substance by a number of other states. The law established the State Public Health Council, of which Mr. Folks has been a member and a vice-chairman since its creation.

From 1923 to 1930, the association was the representative of the Milbank Memorial Fund in the health demonstrations in Cattaraugus County and Syracuse, undertaken for the purpose of showing what benefits could be realized by a typical rural county and a medium-sized city through a more comprehensive application of scientific knowledge as to the prevention of disease and the promotion of health. Mr. Folks took an active part in these demonstrations.

Under the leadership of the state health department, the association, in 1926, joined a coöperative effort for the control of diphtheria in up-state New York through promoting the immunization of young children against that disease. This resulted in a 98 per cent reduction in mortality and sickness from that disease. The association also joined in 1932, at the request of the state health department, the campaign for the prevention and reduction of venereal disease and the promotion of social hygiene.

In 1910, the association's long-time Committee on the Care of the Insane began the promotion of activities for the prevention and earlier diagnosis and treatment of mental disorders. The name of the committee was changed to the State Committee on Mental Hygiene, and it has helped to secure many improvements in the state program for dealing with the insane, including the establishment of out-patient clinics and the employment of psychiatric social workers. Mr. Folks has long been a member of The National Committee for Mental Hygiene, with which the association's state and city committees on Mental Hygiene are affiliated.

In 1940, he was appointed by the governor as chairman of a temporary commission on state-hospital problems to study the increase in the census of the state hospitals for the insane and to recommend what could be done to deal with this problem.

On the recommendation of Mr. Folks, the association established, in 1894, an agency for aiding homeless mothers to care for their children; and in 1898, a child-placing and adoption agency (which has since placed more than 6,700 homeless children in adoptive homes) and the first of a series of county agencies for dependent children in up-state New York.

Mr. Folks was appointed by President Theodore Roosevelt as vice-chairman and presiding officer of the first White House Conference on Dependent Children in 1909. He was chairman of the Committee on Dependent and Neglected Children of the White House Conference on Child Health and Protection in 1929. He also was chairman of the committee that prepared the report and recommendations of the White House Conference on Children in a Democracy of 1939-1940, was a member of its planning and organization committees, and served as vice-chairman of the National Citizens Committee created afterward to urge the adoption of recommendations of the conference.

He is the author of a history of the care of destitute, neglected, and delinquent children in the United States, published by the Macmillan Company in 1902. He has written also many reports, pamphlets, and articles on child welfare.

Under Mr. Folks' direction, the association was instrumental in securing constitutional amendments in 1895 giving constitutional status to the state board of charities and to its powers of inspection — and, in some degree, of regulation — of all charities, public and private. In 1938, the association proposed to the Constitutional Convention a series of amendments, further clarifying the powers and duties of the state social welfare department, and also giving constitutional status to state and local welfare authorities and authorizing adequate powers for them, through the Legislature. Provisions of this nature were passed and are now a part of the state constitution.

As Commissioner of Public Charities of New York City during the years 1902-1903, in the administration of Mayor Seth Low, Mr. Folks reorganized the department and organized the first municipal hospital for tuberculosis in the United States

In 1924, a committee on the coördination of social work in New York City was created, of which Mr. Folks was a member. This resulted in the establishment in 1925 of the New York Welfare Council, which has promoted the coördination of health and welfare activities. Mr. Folks served as chairman of the executive committee of the Welfare Council for many years.

In 1934, the governor appointed Mr. Folks a member of the state

commission on unemployment relief. He served on its executive committee and was chairman of its committee on local welfare organization.

During World War I, Mr. Folks went to France, in June 1917, and organized and directed the Department of Civil Affairs of the American Red Cross Commission to France. He developed bureaus dealing with tuberculosis, child welfare, cripples, relief in the war zone, and relief of refugees throughout France. At the end of the war, Mr. Folks, then a lieutenant colonel of the American Red Cross, made a survey of the civilian populations of Italy, Greece, Serbia, Belgium, and France, to aid the American Red Cross in planning for post-war relief. The results of this study were published by Harper and Brothers (1920) in a volume entitled, *The Human Cost of the War*. In 1921, he made another trip to eastern Europe for the American Red Cross, as a special adviser in organizing its child-health work.

He was elected a member of the first Board of Aldermen of Greater New York, on the Citizen's Union Ticket, in 1897 for a term of two years. In April, 1900, at the request of General Leonard Wood, then military governor of Cuba, he spent six weeks on the island, studying its relief needs. He prepared a charities law and a public-health law for Cuba which were enacted in July 1900. In 1912, he was chosen president of the National Association for the Study and Prevention of Tuberculosis, being the first layman elected to that position. He was president of the American Association for the Study and Prevention of Infant Mortality in 1915, and president of the National Conference of Charities and Correction when it met in Boston in 1911, and again on its fiftieth-anniversary session in Washington, in 1923.

He served as chairman of the United States delegation to the First International Congress of Social Work, held at Paris in July, 1928, and submitted a report on the distribution of the costs of sickness in the United States.

Many other honors have been bestowed upon Mr. Folks. In 1940, he received the Distinguished Service Medal of the Theodore Roosevelt Memorial Association for the promotion of social justice. In 1940 he was elected an alumnus member of Phi Beta Kappa when a chapter was established in Albion College. The degree of Doctor of Laws was conferred upon him by Albion College and Ohio Wesleyan University in 1911. For his services in World War I, he was decorated by the government of Yugoslavia with the Order of the White Eagle and the Order of St. Sava, and by the French government with the Legion of Honor.

Rowland Burstan Elected Executive Director of State Charities Aid Association

Rowland Burnstan, economist, educator, and executive, has been elected executive director by the Board of Managers of the New

York State Charities Aid Association to succeed Homer Folks. Mr. Burnstan assumed his new duties on March 1.

Born in Scranton, Pa., November 9, 1901, Mr. Burnstan is a graduate of Lafayette College, with degrees of B. S. and A. M. In 1929 he obtained a degree of Ph. D. from Columbia University, which also awarded him a traveling fellowship for research in Western Europe. In 1938 he received an Sc. D. from the University of Chicago.

From 1932 to 1937, he practiced as a consulting management engineer in Chicago and New York. During this period he was a lecturer on economics at the University of Chicago. He became professor of economics at Carleton College in 1937, resigning in 1941 to assume the post of Director of the Aëronautical Division of the Minneapolis-Honeywell Company. Since 1943, he has been President of the Lawrance Aëronautical Corporation.

He served as a member of the Advisory Committee of the Minnesota Institute of Governmental Research and on the Minnesota State Planning Board, and he represented New York State at the National Tax Association in 1929. He was also a member of the League of Nations Committee to study the Organization of Peace.

Mr. Burnstan is the author of books on taxation and other economic subjects published in English and German, and of articles on aeronautics. He is a fellow of the Royal Economic Society, a member of the American Economic Association, of the Academy of Political Science, and of the American Association for the Advancement of Science, and an associate fellow of the Institute of Aëronautical Sciences, and of the Royal Aëronautical Society.

Princeton University Undertakes a Study of Student Development and Educational Procedures

A systematic analysis of student development and educational procedures will be undertaken by Princeton University, according to a recent announcement by Dr. Harold W. Dodds, president of the university. The study, believed to be unique in the field of higher education, is made possible by a grant of $200,000 from the Carnegie Corporation of New York. It is estimated that it will require at least five years to complete. The objective of the project, according to the announcement, is "the systematic and critical examination of residential life, including both instructional programs and extracurricular activities, to determine, as far as may prove possible, their results measured by the intellectual, moral, and physical development of the students."

The Princeton investigation will be a university-wide project, attached to the office of the dean of the faculty and supervised by an advisory committee composed of all elements of the university. The

opening phase of the long study will begin with statistical analyses of existing university records of a student's standing at entrance, his scholastic aptitude rating, and his academic performance and extra-curricular participation with a view to ascertaining their interrelationship, if any.

Later steps, to be taken in the light of knowledge and experience obtained from the initial analyses, will call for the active participation of students, alumni, and faculty, ranging from "tests of scholastic aptitude, of personality traits, of attitudes and motives" to possible "specific experiments in instructional techniques carried out under specified conditions."

President Dodds emphasized that the project is "an experiment in self-appraisal," and "not a proposal for the reformation of teaching methods or of academic policy." Instead, it is a project, he said, "to discover the facts needed for the intelligent consideration of problems of policy."

He expressed the hope that the study might provide factual information helpful in resolving some of the "intuitive presuppositions and unanswered questions and doubts" which beset many attempts "to develop a liberal-arts education appropriate to the conditions of our time."

President Dodds said he expected that over a period of time the project would have significance for the entire field of college education. "At a minimum," he observed, "it can substitute ascertained fact for opinion in some crucial areas. At a maximum, it may open up new educational horizons through greater self-knowledge as to those elements of our program which are failing and those which are successful, and why."

College Health Conference to Meet in New York in May

Thirty-five leading organizations in health and education will sponsor the Third National Conference on Health in Colleges to be held in New York City, May 7 to 10, 1947. The first meeting of its kind in more than ten years, the Third National Conference on Health in Colleges is called to meet new health problems that have arisen during the post-war period.

Invitations to attend the conference, or to appoint delegates to represent the institution, have gone to the presidents of more than 900 colleges and teacher-training schools in the United States. Alexander G. Ruthven, Ph. D., President of the University of Michigan, is president of the conference.

National organizations primarily sponsoring the conference include the Association of American Colleges; the American Association of Teachers Colleges; the American Student Health Association; the

American Association for Health, Physical Education, and Recreation; and the National Health Council.

National School Health Services Bill

A bill to appropriate 12 million dollars for the purpose of assisting states and territories to extend and improve their health services for school children between the ages of five and seventeen, has been introduced by Representative Evan Howell (R. 21st Ill.)

The bill specifies that one-half of the federal appropriation, which would be extended to 18 million after the first year of operation, would be matched by state funds on a dollar-for-dollar basis, to be spent in the development of services for the prevention, diagnosis, and treatment of physical and mental defects among school children. The other half of the federal appropriation, which would not need to be matched, would be allocated to the states according to their needs.

With the long-range objective of assuring that no American child should grow up with physical or mental defects that could be prevented or corrected in childhood, the National School Health Services bill would assist the states to:

1. Provide more thorough health examinations for school children to determine whether they are gaining weight as they should and to discover defects of the eyes, teeth, ears, heart, lungs, throat, and posture.

2. Provide children with follow-up medical care to correct defects discovered in such examinations. Since not enough money can be made available at once to provide all school children with medical care, Representative Howell's bill would have remedial work done especially in rural areas and areas of severe economic distress, where the need is greatest. States would be required to supply equitable services without regard to race, color, or creed.

States would be expected to integrate the new services made possible with funds from the Howell Bill with health activities already under way, and with the health and medical facilities presently available in the communities.

The act would be administered by the Federal Security Administration, under a school health services board. This board would consist of the chief of the Children's Bureau as chairman, the United States Commissioner of Education, and the Surgeon General of the United States Public Health Service. State planning for services and administration of funds would be left entirely to the states, and there would be no federal interference with state educational systems.

In introducing the bill, Representative Howell stated that it should not be confused with proposals for national medical insurance and is not a step toward socialized medicine. He said that the bill has already won "a large measure of public support."

He pointed out that draft rejections during the recent war indicated that there had been no real advance in the health of the adult male population since the last war. "Many of the defects which disqualified millions of young men for military service could have been detected and corrected when the men were boys in school. Schools are the best place to begin improving the nation's future health. The bill represents real economy, spending a relatively small sum to-day so that larger sums would not be needed later. If we want to have a healthy nation, we must start with the children."

Eastern Pennsylvania Psychiatric Institute

The Joint Medical-Legal Commission of the Philadelphia County Medical Society, after a number of meetings, recommends that the Eastern Pennsylvania Psychiatric Institute, discussed some years ago as a needed adjunct to the state mental-hospital system, should be constructed at once. This institute would offer to the eastern end of the state the same types of facility now available in the western area through the Western State Psychiatric Institute and Clinic.

The primary purpose of this institute, to be located in Philadelphia, would be for research and training. It would be closely allied with five schools of medicine in the Philadelphia area and other training schools such as the Philadelphia School of Occupational Therapy, the Pennsylvania School for Social Work, and so on. Besides fundamental research and treatment in psychiatric conditions, the question of training personnel for the care of the mentally ill in medical, nursing, attendant, social work, and other ancillary occupations would be a matter of study and practice, with the aim of developing a much more highly specialized personnel group for such work in the entire state mental-institutional system.

Some years ago the Public Charities Association of Pennsylvania went on record approving the construction of two institutions for research and training in the mental-hygiene field, one of which was constructed just before the war, in Pittsburgh, and is now known as the Western State Psychiatric Institute and Clinic. This is operated directly by the department of welfare with no board of trustees. At the present time it has a population of 120 patients at a per capita daily operating cost of $11.20.

The committee recommends and urges that the Eastern Pennsylvania Psychiatric Institute be constructed now for the purposes outlined above. A bed capacity of between 200 and 300, necessary space for laboratories and teaching appurtenances, and an out-patient department are to be included in the original plans. It has been tentatively suggested that the present grounds of the Eastern State Penitentiary would be adequate for this institute and would soon be available since the penitentiary is being moved to another site.

Venereal-Control Council Established

The war department recently announced the establishment of a venereal-disease-control council for the purpose of insuring that all possible control measures are employed and of reducing the rate of venereal disease in the army.

The council will meet each month to consider venereal-disease problems as they affect service personnel, to develop standard educational and control measures, and to review control procedures adopted in the field. In addition, it is authorized to take immediate corrective action when reports indicate the existence of unsatisfactory conditions that are beyond the control of the local or army commander and to establish policies for the reduction and control of venereal disease based on appropriate research studies, surveys, and field experience. It will also coördinate and assist the Joint Army and Navy Disciplinary Control Board on disciplinary problems related to venereal-disease control.

Major General Willard S. Paul, Director of Personnel and Administration, has been designated as chairman of the council. Other members already appointed are Major General Norman T. Kirk, The Surgeon General; Major General Floyd L. Parks, Chief, Public Relations Division; Chaplain (Major General) Luther D. Miller, Chief of Chaplains; Brigadier General Russell B. Reynolds, Chief, Special Service Division; Brigadier General Blackshear M. Bryan, The Provost Marshal General; and the recorder, Lieutenant Colonel John J. Easton, Personnel and Administration Division.

Representatives of the Secretary of War, the army ground forces, and the army air forces will be named to the council early in January.

The army continued its drive against venereal disease in another way with the opening of the first post-war classes in venereology at a civilian institution in December, 1946, at the University of Pennsylvania, Philadelphia, with sixteen army-medical-department officers enrolled.

Major General Norman T. Kirk, Surgeon General, said that the officers would study for two months in the Institute for the Study of Venereal Disease at the university before returning to their stations in army general hospitals and air forces. Another class was scheduled to open in January at the University of Southern California, Los Angeles.

General Kirk explained that such courses had become necessary so that medical officers versed in venereology could replace the venereal-disease specialists who are being separated from the service. Rapidly changing treatment policies also require that a trained venereologist administer the army's program of treatment for venereal disease.

"This abbreviated course will not give us specialists in venereal-

disease management," General Kirk declared, "but it will be a step in the right direction. We must have regular-army and Category I medical officers to replace those specialists in venereology who are being separated from the service and to assure uninterrupted work in venereal-disease control. Expert civilian consultants in this field are also available to the army."

Dr. John H. Stokes, Director of the Institute For The Study of Venereal Disease and professor of dermatology-syphilology in the Graduate School of Medicine, University of Pennslyvania, conducted the two-month course. Dr. Stokes is a medical consultant to the Secretary of War through The Surgeon General.

California Launches Broad Mental-Hygiene Program

The state of California has recently embarked upon a new and progressive program for the prevention and treatment of mental disease and mental deficiency, and preparation is already under way for the construction of several new mental institutions and for the modernization of existing facilities. In the words of Governor Warren:

"The Department of Mental Hygiene which has charge of these institutions has been completely revitalized. It is now well launched on a program which will provide treatment facilities for these patients, unsurpassed in the nation. The old-fashioned asylum will be a thing of the past in California. We are entering into an era where mental illness will be treated as something requiring special hospitalization and care.

"This same department is now pioneering in prevention fields, and I am confident the day will soon come when the benefits of modern preventive knowledge will be offered in mental clinics throughout the state. Such clinics are now established in Los Angeles and San Francisco, and I am advocating their expansion to San Diego, Fresno, Sacramento, and other communities. For the first time in its history, California is reaching out to help people while they are in the first phases of mental illness—people who, without attention, might soon be patients in its hospitals."

The director of the department of mental hygiene has appointed Dr. Lawrence Kolb, former Chief of the Mental Hygiene Division of the United States Public Health Service, to the position of deputy director, medical, to develop and administer a program of raising treatment standards to the highest possible level and generally to promote mental health in the community. A new position of director of clinical services has also been established at each one of the mental institutions in the state of California. These positions carry responsi-

bility for the supervision of medical activities in the institution and the development of a teaching and research program. The clinical directors holding these positions will be relieved of administrative responsibilities in so far as possible, so that they may devote their full attention to the medical aspects of their work.

The Langley Porter Clinic under Dr. Karl M. Bowman, in San Francisco, which operates in conjunction with the University of California, is also included in the department of mental hygiene. This institution offers an intensive twelve-week refresher course in psychiatry, and physicians employed by the department are eligible for assignment to the clinic to participate in this course.

At present there are available in the department positions for physicians and surgeons, psychiatrists, and clinical directors. Salaries range from $345 to $715 per month, depending upon experience and training. Veterans will receive special consideration for appointment and will receive extra credit in civil-service examinations. Physicians who are licensed in any other state may practice in a California mental institution for one year before securing their California license.

Inquiries should be addressed to F. E. Kline, State Personnel Board, 401 State Building, Los Angeles, California.

New York State Seeks Psychiatrists and Psychologists

The state of New York, aiming to expand its treatment, training, and research services in its mental-health, child-guidance, and delinquency-prevention programs, has opened additional opportunities in these fields for professional workers who are residents of New York State.

Two grades of research psychiatrists (senior and assistant) are sought for special projects of laboratory and clinical character in the rapidly developing program of the state department of mental hygiene. This department's research centers are located in Syracuse and in New York City. The recently announced bio-psychologic research project also embraces Rockland State Hospital at Orangeburg, New York. Research psychiatrists in the senior group will collaborate in various types of research, participate in staff conferences, and carry on some of the teaching activities either at Syracuse University Medical School or at the College of Physicians and Surgeons of Columbia University. Assistant research psychiatrists will engage in laboratory and clinical programs, or they may supervise a children's admission service or have immediate charge of an encephalography department. The salary range in the senior grade is $4,560 to $5,700; in the assistant grade, it is $3,681 to $4,560.

The accelerated program of child guidance and preventive psychiatry has created a need for psychologists also. Senior psychologists (at $3,681 to $4,560 a year) are sought for state and county departments and institutions. Junior psychologists (at $2,268 to $2,806 a year) are needed for institutions and for the department of mental hygiene's division of prevention (main office at Albany).

A senior psychologist will be expected to organize and direct the work of the psychological service of a state institution, carry out various types of psychological service, and recommend and participate in treatment and training programs. Junior psychologists will administer and interpret psychometric tests of both routine and special diagnostic nature, carry out experimental research and, through consultations, offer guidance on the management of behavior problems.

Complete information on duties, qualifications, and the mechanism of applying for an examination may be obtained by writing to: State Department of Civil Service, Albany, New York. Applicants must enclose a long self-addressed envelope bearing six cents in postage, and they must specify the titles and the numbers of positions in which they are interested. These are: Senior Research Psychiatrist, No. 4359; Assistant Research Psychiatrist, No. 4332; Senior Psychologist, No. 4358; Junior Psychologist, No. 4352.

New York State Postwar Public Works Planning Commission Approves Five New Projects

Five new projects, with estimated construction costs totaling $2,907,292, have been approved for planning by the New York State Postwar Public Works Planning Commission, Budget Director John E. Burton, chairman of the commission, announced to-day. The new approvals increase to 118 the number of projects approved for mental hygiene. Ross E. Sluyter, director of state planning for the commission, said that construction costs for all the projects approved for this department now total $96,000,000 on the basis of 1940 costs.

The largest of the new projects approved, with a 1940 cost estimate of $1,441,000, calls for service connections and ground improvements at Rome State School, where practically a new institution is being planned. The program of expansion at this institution, Mr. Sluyter said, calls for eventual demolition of thirty-four existing structures, all of which are in very poor condition. Approval of the new project will permit planning of a comprehensive system of water and sewer lines and heating tunnels, roads, walks, and landscaping.

Planning for a power plant and an incinerator at Willard State Hospital at an estimated cost of $951,622 was also approved. The new plant will be designed to meet the needs at Willard when its program

of expansion is completed. The existing power plant will be converted into a general repair shop and garage.

Also approved were proposals to provide: 1. A system of hard-surface roads, sidewalks, and curbs, and a surface drainage system at Harlem Valley State hospital, at an estimated cost of $346,810. Dirt roads at the institution now serve as both roads and walks. 2. A new 500,000 gallon elevated water tank to provide water for the proposed tuberculosis hospital at Central Islip State Hospital, at an estimated cost of $145,860. 3. A new sewage pumping station at Newark State School at an estimated cost of $22,000. The present pumping station, whose capacity is insufficient to handle the increased flow when the school's building program is completed, will be abandoned and removed.

Influence of War and Business Cycles on Prevalence of Alcoholism

An apparently inverse relationship between the prevalence of alcohol psychoses and the existence of a state of war, was pointed out by Dr. Benjamin Malzberg, Director of the Statistical Bureau of the New York State Department of Mental Hygiene, in an address before the February Bimonthly Conference of the directors of New York State's mental institutions.

"In spite of the continued growth of the state's general population," stated Dr. Malzberg, "there was a decrease in the number of first admissions with alcoholic psychoses to New York civil state hospitals from 1909 to 1920. After 1920, however, the rate climbed year by year until 1941, when it was the highest ever recorded in New York State. For the three-year period ended June 30, 1941, the average annual rate of first admissions with alcoholic psychoses was 7.8 per 100,000 general population."

Since 1941, however, the rate has again declined. During the fiscal year ended March 31, 1944, there was an estimated annual rate of 4.9 first admissions with alcoholic psychoses per 100,000. It, therefore, appears that the rate of first admissions decreased during the war.

A similar decrease was noted during World War I, but at that time there were limitations upon the manufacture and sale of intoxicating liquors which might have explained the reduction in alcoholic psychoses. During World War II, however, there were no such restrictions. Consequently there is some reason for believing that an influence generated by preparation for and the conduct of war may, at least temporarily, cause less drinking of a kind and degree that result in a psychosis.

There is also a possibility, Dr. Malzberg stated, that "the rate of first admissions with alcoholic psychoses is related to business trends.

It is probable that the prevalence of the alcoholic psychoses, as of all mental illness, is reduced during periods of prosperity and increased during a period of depression.

"Whether this is a complete explanation of the changing trends in the prevalence of the alcoholic psychoses cannot be asserted with finality."

An analysis of the characteristics of first admissions with alcoholic psychoses in all mental hospitals in New York State gives the following findings: 1. The alcoholic psychoses are more prevalent among males than among females. 2. They are more frequent in the summer. 3. Groups with higher levels of education have lower rates of alcoholic psychoses than those with lower levels of education. 4. Among males lower rates of alcoholic psychoses occur among the married men than among the unmarried. 5. Urban populations have higher rates of first admissions of this condition than rural populations.

Residency Training Programs in Neurology Offered by Veterans Administration

Two additional residency training programs for Veterans Administration physicians interested in neurology have been organized. The residencies, which will vary from one to three years, according to a doctor's previous experience, are designed to prepare residents for certification in neurology by the American Board of Psychiatry and Neurology.

One training program will be conducted under the joint auspices of Boston University, Tufts Medical College, and Harvard University. Residents will be stationed at the Veterans Administration Hospital at Framingham, Massachusetts (formerly the army's Cushing General Hospital), which has special units for the study of epilepsy, aphasia, paraplegia, and electroencephalography, and a complete diagnostic neurological service. Applications should be sent to Dr. Harry C. Solomon, Chairman, Deans Subcommittee for Neuropsychiatry, Harvard University Medical School, Boston, Massachusetts.

The other training program will be conducted at Jefferson University Medical College and Clinic, Philadelphia, Pennsylvania, under the auspices of the Veterans Administration Philadelphia Deans Committee. Dr. Bernard J. Alpers, professor of neurology at the Jefferson Medical College, will direct the program. Applications should be sent to Dr. Edward A Strecker, Chairman, Deans Subcommittee for Neuropsychiatry, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania.

Veterans Administration training programs in neurology already under way are: One under the joint auspices of Cornell University and Columbia University medical schools; residents stationed at the

Veterans Administration Hospital, Bronx, N. Y.; applications received by Dean Willard C. Rappleye, 430 West 168th Street, New York City.

One under the auspices of Northwestern University and the University of Illinois; residents stationed at the Veterans Administration Hospital at Hines, Illinois; applications received by Dr. Lewis J. Pollock, Northwestern University, Chicago.

One under the auspices of the University of Minnesota, with residents stationed at the hospital at Minneapolis; applications received by Dean Harold S. Diehl, University of Minnesota Medical School, Minneapolis, Minnesota.

Three-Year Residency in Neuropsychiatry Offered

The Southwestern Medical Foundation in coöperation with the Veterans Administration is offering a three-year residency in neuropsychiatry. Two years of this are divided into eight-month rotation periods between the Dallas area and the Veterans Administration hospitals at McKinney and Waco, Texas. The third year is elective, and investigative work is included. Approximately one-half of the required time covers psychosomatic medicine and mental-hygiene work, including child guidance. The other half is inpatient psychiatry. For further information write to Dr. Don P. Morris, Secretary of the Dean's Subcommittee for Neuropsychiatry, Southwestern Medical College, 2211 Oak Lawn Avenue, Dallas 4, Texas.

Neuropsychiatric Consultants to War Department Meet

Leading psychiatrists of the nation who are consultants to the Secretary of War met in Washington, January 20 and 21, to discuss future war-department neuropsychiatric policies, according to a statement recently issude by Major General Norman T. Kirk. "Panel discussions were held in the Office of The Surgeon General," General Kirk said, "for a review of current neuropsychiatric practices and techniques and for a consideration of long-range plans."

All the doctors attending the two-day conference had been assigned to active duty as members of the army medical department during the war.

Dr. William C. Menninger, Chief of the Neuropsychiatry Consultants Division of the Surgeon General's Office during the war, with the rank of brigadier general, who is chairman of the Secretary of War's consultants, presided at the meeting. Colonel J. M. Caldwell, present Chief of the Neuropsychiatry Consultants Division, took part in the discussion.

In a press conference after the meeting, Dr. Menninger discussed the progress of military neuropsychiatry during the war, and pointed

out how the experience gained in dealing with some of the problems encountered would enable a better handling both of a peace-time army and of any army mobilized in the future. Dr. Menninger stressed the importance of good leadership, proper motivation, and identification of the individual with his unit for the maintenance of the good mental health of the soldier. He also emphasized the importance of early recognition of the factors and symptoms that lead up to the soldier's neuropsychiatric breakdown, if the potential mental casualty is to be prevented.

Books and World Recovery

The desperate and continued need for American publications to serve as tools of physical and intellectual reconstruction abroad has been made vividly apparent by appeals from scholars in many lands. The American Book Center for War Devastated Libraries has been urged to continue meeting this need at least through 1947. The center is, therefore, making a renewed appeal for American books and periodicals — for *technical and scholarly books and periodicals in all fields* and particularly for *publications of the past ten years.* Complete or incomplete files of Mental Hygiene will be especially welcome.

The generous support that has been given to the book center has made it possible to ship more than 700,000 volumes abroad in the past year. It is hoped that this amount may be doubled before the center closes. The books and periodicals that your personal or institutional library can spare are urgently needed and will help in the reconstruction that must preface world understanding and peace.

Ship your contributions to the American Book Center, c/o The Library of Congress, Washington 25, D. C. freight prepaid, or write to the center for further information.

News of Mental-Hygiene Societies

Compiled by

Justin G. Reese

Field Representative, Division of State Mental Hygiene Organization, The National Committee for Mental Hygiene

California

Under the direction of Mrs. Helene W. Lipscomb, its executive director, the Southern California Society for Mental Hygiene has been broadening its field of interest. Among recent activities was a joint sponsorship with the Los Angeles Welfare Council of a conference on alcoholism, which was attended by six hundred people.

Connecticut

High light of the activities of the Connecticut Society for Mental Hygiene has been the securing of legislative support for a Connecticut child-study home, providing for the treatment of emotionally disturbed and maladjusted children under sixteen years of age. The Connecticut Society has secured the coöperation and sponsorship of a number of important organizations in this matter.

Delaware

The Delaware State Society for Mental Hygiene is sponsoring four bills now before the state legislature, calling for a welfare and health center for the care and treatment of alcoholics, epileptics, and problem children, and for the erection of a new building for the criminally insane.

Florida

Plans for a mental-hygiene society are being developed by a committee of the Orlando Community Welfare Planning Council. The chairman of the mental-hygiene committee is Mrs. Helen Drew Martin. The committee already has held a one-day institute. Recently members of the committee and representatives of the community met with Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene, to discuss public-education programs and plans for setting up some type of over-all mental-hygiene organization for central Florida. Active coöperation for the project has been furnished by Miss Frances James, Executive Secretary of the Community Welfare Planning Council.

Georgia

The Atlanta Mental Hygiene Committee has elected Dr. Joseph S. Skobba as its new president.

Illinois

The thirty-eighth Annual Meeting of the Illinois Society for Mental Hygiene was held on March 20. The principle speaker was Dr. Andrew C. Ivy, Vice President of the University of Illinois in charge of Chicago professional schools. An outstanding educator, research scientist, and administrator, Dr. Ivy spoke on "Appetites."

Reports were delivered by Ronald P. Boardman, president of the society, and Dr. Rudolph G. Novick, its medical director. Greetings from The National Committee for Mental Hygiene were delivered by Justin G. Reese, field representative of the National Committee's Division of State Mental Hygiene Organization.

Massachusetts

The Massachusetts Society for Mental Hygiene regrets to announce the death of Miss Bernice Henderson, which occurred in December 1946. Her long service to the society, first as educational secretary and after 1942 as executive secretary, is a record of important achievement in the field of mental hygiene. Her unusual clarity of mind, combined with her skill as an administrator, in a field requiring much adaptability to people in the whole range of human affairs, made her of rare value to the society as well as to the many friends in community groups throughout the state. Her interests knew no state boundaries, however, and we feel that the cause of mental hygiene in a wide area has suffered a serious loss.

Because of her long and active identification with the development of psychiatric social work and education in this field, a group of friends feel that an appropriate commemoration of her work may be made in the form of a scholarship fund to be used by the school of which she herself was a graduate. Contributions should be sent direct to the Smith College School of Social Work, College Hall, Northhampton, Massachusetts, marked, "In memory of Bernice Henderson."

Minnesota

Expansion of the Minnesota Mental Hygiene Society is envisaged through a five-year state-wide program. The medical director of the society, Dr. Alexander Dumas, and its president, Dr. Alan Challman, report progress. The society's new address is 926 Metropolitan Life Building, Minneapolis 1.

New York

The New York State Committee on Mental Hygiene is assisting the Veterans Administration to secure treatment for neuropsychiatric veterans. Since there is a serious shortage of mental-hygiene clinics, the program consists of securing good part-time service wherever it can be found. The Veterans Administration has made contracts so far with twelve clinics, some of them assembled on part time for the purpose, with trained personnel who are already in the community, but who have not previously acted as a clinic team.

The most recent development is that the Veterans Administration has signed contracts with the traveling clinics of the New York State Department of Mental Hygiene. These clinics, chiefly for child guidance, close at four o'clock. Either from 4–6 or from 7–10 the staff will hold one or more sessions a week for neuropsychiatric veterans in smaller towns in which the numbers of such veterans are

not high. This over-time service will be paid for by the Veterans Administration fees to the clinic.

It is believed that plans already in effect or developing will eventually provide fairly adequate service. There will be full-time Veterans Administration units in the largest cities, part-time contract clinics in medium-sized cities, and part-time service from traveling clinics in small cities and rural areas.

The Mental Hygiene Society of Monroe County recently acted as host at a public meeting to Dr. T. M. Ling, Medical Director of the Roffey Park Rehabilitation Center, Horsham, Sussex, England. Dr. Ling described the work of the center.

Oklahoma

The Oklahoma Committee for Mental Hygiene has opened offices in conjunction with the Oklahoma State Medical Association at 210 Plaza Court, Oklahoma City. The executive secretary is Mrs. Lucy May Smith; the president, Mrs. Francis Leech, of Tulsa.

The Oklahoma Committee is coördinating an organizational and a legislative campaign. As a result of the committee's activities and the articles by Mike Gorman in *The Daily Oklahoman,* legislative appropriations are expected to be higher than in previous sessions. Membership in the committee is steadily growing, with 73 communities represented.

Oregon

The month of March saw a series of three lectures on "Living Together," given by Dr. Lawrence Riggs, Dean of Students, Willamette University.

On April 28, 29, and 30, the society, in co-sponsorship with the E. B. Brown Trust of the University of Oregon Medical School and the Oregon State Board of Health, will conduct an institute for social workers under the direction of Dr. James Plant, Chairman of the Executive Committee of The National Committee for Mental Hygiene, and Director of the Essex County (N.J.) Juvenile Clinic. Dr. Plant is also scheduled to speak at the Northwest Conference on Family Relations and before other groups.

Tennessee

Plans for a state mental-hygiene society were developed on March 19 in connection with the State Conference of Social Work in Memphis. An organizational meeting in coöperation with the Tennessee State Medical Society will be held in May. It is hoped that other state organizations will participate in this meeting. Miss Ruby

Lanier, Executive Secretary of the Chattanooga Council of Community Forces, has been prominent in developments.

Texas

The Texas Society for Mental Hygiene held its annual conference in San Antonio on April 10, 11, and 12. The emphasis of the conference was upon the function of community clinics, education, and group work.

Among outstanding authorities participating were Dr. George E. Gardner, Executive Director, Judge Baker Guidance Center for Childhood and Youth, Boston; Dr. Lloyd Cook, Wayne University; Dr. Lucile Allan, Counselor of Women, Cornell University; Mrs. Gertrude Wilson and Gladys Ryland, University of Pittsburgh; and Dr. George S. Stevenson, Medical Director, The National Committee for Mental Hygiene.

Virginia

New officers of the Mental Hygiene Society of Virginia are: Joseph R. Blalock, M.D., Marion, president; Abner Robertson, D.D. Richmond, vice president; R. W. Garnett, M.D., Danville, corresponding secretary; Claude L. Neale, M.D., Richmond, treasurer; and F. W. Gwaltney, Richmond, executive secretary.

Wisconsin

The Wisconsin Society for Mental Health has embarked on a program for public education in day institutes on mental-health problems, sponsored by women's clubs. While devoting its attention to public education, it is promoting legislation for the improvement of mental hospitals.

Recent Appointments

Announcement has been made that Dr. Robert P. Knight, at present Chief of Staff of the Menninger Clinic, Topeka, Kansas, has been appointed Medical Director of the Austen Riggs Foundation, of Stockbridge, Massachusetts. He will assume his new duties on September 1.

Dr. Knight was born in Ohio in July, 1902. He graduated from Oberlin in 1923 with a Phi Beta Kappa; and after teaching for a few years, entered Northwestern University Medical School, from which he graduated in 1932. After a year's rotating internship, he joined the staff of the Menninger Clinic. There by 1936 he had become chief of the department of psychotherapy, and in subsequent years was made, successively, chief of staff and director of the department of clinical services.

In the course of those years he completed training in the Chicago Institute for Psychoanalysis, became assistant director of the Topeka Institute for Psychoanalysis, secretary of the American Psychanalytic Association (1943), president of the American Psychopathological Association (1945), and president of the Kansas Psychiatric Society. He has been professor of clinical psychiatry in the Menninger Foundation School of Psychiatry, and assistant director of the school. He is a member of many scientific societies, a fellow of the American Psychiatric Association, and a member of the Central Neuropsychiatric Association.

Dr. Knight has made many significant contributions to psychiatric knowledge, in such fields as the problems of alcoholism, the special techniques of psychotherapy in hospitals, the problems of adopted children, and military neuropsychiatry.

Hester B. Crutcher, Director of Psychiatric Social Work, New York State Department of Mental Hygiene, has accepted an appointment to the Advisory Council of Psychiatric Social Work of the United States Public Health Service.

This council is to consist of five members who will advise Jack Stipe, Chief Psychiatric Social Worker of the United States Public Health Service, on such problems as personnel, standards, and methods of carrying out the provisions of the National Mental Health Act. Since the lack of trained psychiatric social workers is a major problem, grants of financial aid for specialized training will also be taken into consideration. The advisory council will be indirectly responsible to Dr. R. H. Felix, Medical Director, Chief of the Mental Hygiene Division, United States Public Health Service.

New Publications

The Association for the Advancement of Psychotherapy has announced that as of January, 1947, the official organ of the association will be the *American Journal of Psychotherapy*. Emil A. Gutheil, M.D., 16 West 77th Street, New York 24, is the editor. The journal will be a quarterly, issued in January, April, July, and October. Annual subscription: $8.00; special annual rate to the members of the association: $6.00.

A new journal, *Sociatry, Journal of Group and Inter-Group Therapy*, made its appearance in January. Announced as a sister journal to *Sociometry*, a journal of interpersonal relations, now in its tenth year, the new journal is particularly dedicated to the development of methods in group psychotherapy and action therapy, such as psychodrama, sociodrama, rôle training, and so on. Its editor is Dr. J. L.

Moreno, of Beacon, New York. Annual subscription: $5.00; single copy: $1.50.

A list of bulletins, monographs, and books in the field of reading disabilities has been issued by the Reading Clinic of Temple University. A copy of the list, including prices of the various publications, may be obtained from Emmett A. Betts, Director of the Reading Clinic, Temple University, Philadelphia 22, Pennsylvania.

A new Occupational Abstract, *Medical Social Work*, containing the latest information about the field, is now available for 25¢ a copy through Occupational Index, Inc., New York University, New York 3, N. Y. Containing information valuable to vocational counselors, students, and any one interested in entering the field, this six-page pamphlet describes the nature of the work, the qualifications and preparation required, methods of entrance and advancement, number and distribution of workers, discrimination, earnings, and the advantages and disadvantages of the profession. Included also are professional periodicals, sources of further information, and a selected list of supplemental reading.

CURRENT BIBLIOGRAPHY*

Compiled by

EVA R. HAWKINS

The National Health Library

Abrahams, Joseph, M.D. and McCorkle, L. W. Group psychotherapy at an army rehabilitation center. Diseases of the nervous system, 8:50–62, February 1947.

Ackerman, Nathan W., M.D. Anti-semitic motivation in a psychopathic personality. Psychoanalytic review, 34:76–101, January 1947.

Adams, Kathryn. Counseling against family breakdown. Marriage and family living, 9:8–10, February 1947.

Ahronheim, J. H., M.D. Emotional albuminuria in combat. Psychosomatic medicine, 9:51–57, January–February 1947.

Allen, Clara M. Day care centers for school children. Child welfare league of America, Bulletin, 26:7, 12–15, February 1947.

Alvarez, Walter C., M.D. The migrainous personality and constitution. The essential features of the disease: a study of 500 cases. American journal of the medical sciences, 213:1–8, January 1947.

Anderson, Irving H. The concept of remedial reading. Journal of exceptional children, 13:97–101, January 1947.

Antman, Joseph. Social worker in khaki: report on an unsheltered casework job. Survey midmonthly, 82:294–95, November 1946.

Austin, Lucille N. Current developments in case work in the family field as they relate to psychiatry. News-letter, American association of psychiatric social workers, 16:46–48, Autumn 1946.

Barry, Herbert, Jr., M.D. Abnormally large birth weights of psychiatric patients. Archives of neurology and psychiatry, 57:98–101, January 1947.

Barwise, Constance, M.D. Community resources in prevention of mental illness. Mental hygiene news, New York state department of mental hygiene, 17:8, December 1946. (To be continued.)

Bates, Sanford. Social problems of the prisoner. Part II. Federal probation, 10:11–15, October–December 1946.

Beck, Ruth E. Foster family care in crisis. Survey midmonthly, 83:37–39, February 1947.

Bellak, Leopold, M.D. and Willson, Elizabeth. On the etiology of dementia præcox: a partial review of the literature, 1935 to 1945, and an attempt at conceptualization. Journal of nervous and mental disease, 105:1–24, January 1947.

Bender, Lauretta, M.D. Childhood schizophrenia; clinical study of one hundred schizophrenic children. American journal of orthopsychiatry, 17:40–56, January 1947.

Bergler, Edmund, M.D. Elderly neurotics. Diseases of the nervous system, 8:35–36, February 1947.

Bergler, Edmund, M.D. Newer genetic investigations on impotence and frigidity. Bulletin of the Menninger clinic, 11:50–59, March 1947.

Bergler, Edmund, M.D. Specific types of resistance in orally regressed neurotics. Psychoanalytic review, 34:58–75, January 1947.

Bergman, Paul. Analysis of an unusual case of fetishism. Bulletin of the Menninger clinic, 11:67–75, March 1947.

Bergmann, Martin S., Graham, Herbert and Leavitt, H. C. Rorschach exploration of consecutive hypnotic chronological age level regressions. Psychosomatic medicine, 9:20–28, January–February 1947.

Bettelheim, Bruno. Self-interpretation of fantasy. The Thematic apperception test as an educational and therapeutic device. American journal of orthopsychiatry, 17:80–100, January 1947.

Bick, John W., Jr., M.D. Observations on current army psychiatric problems: a comparison of out-patient records of January 1944 and January

* This bibliography is uncritical and does not include articles of a technical or clinical nature.

1946. Journal of nervous and mental disease, 105:73–76, January 1947.

Biernoff, Joseph, M.D. The traumatic neuroses of industry. Industrial nursing, 5:15–23, November 1946.

Binger, Carl, M.D. Medical information and misinformation. Mental hygiene, 31:1–13, January 1947.

Blacker, Carlos P. Social problem families in the limelight. Eugenics review, 38:117–27, October 1946.

Blackwell, Ethel and Neal, G. A. Music in mental hospitals. Occupational therapy and rehabilitation, 25:243–46, December 1946.

Blain, Daniel, M.D. The Veterans administration plots a new course. Hospitals, 20:38–42, December 1946.

Blain, Daniel, M.D. and Baird, J. H., M.D. The neuropsychiatric program of the Veterans administration. American journal of psychiatry, 103: 463–66, January 1947.

Blank, Hymen R., M.D. An aid in the training of neuropsychiatric ward officers. Bulletin, U. S. Army medical department, 7:116–20, January 1947.

Bloch, Herbert A. The personality of inmates of concentration camps. American journal of sociology, 52: 335–41, January 1947.

Blos, Peter. The essence of adolescent change. Child study, 24:43–45, 62–63, Winter 1946–47.

Boland, Ruth F. High school pupils with I.Q.'s below 75. Understanding the child, 16:11–14, January 1947.

Bolgar, Hedda and Fischer, L. K. Personality projection in the World test. American journal of orthopsychiatry, 17:117–28, January 1947.

Boll, Ernest. Social causation in the English novel of the Armistice interval. Psychiatry, 9:309–21, November 1946.

Bond, Earl D., M.D. and Shurley, J. T., M.D. Insulin therapy and its future. American journal of psychiatry, 103: 338–41, November 1946.

Bongiovanni, Alfred M. Psychometric examinations aboard a destroyer. U. S. naval medical bulletin, 47: 27–32, January–February 1947.

Borman, Milton C., M.D. The occupational therapist and psychosomatic therapy. Occupational therapy and rehabilitation, 25:215–18, December 1946.

Bowman, Henry. The teacher as counselor in marriage education. Marriage and family living, 9:1–7, 12, February 1947.

Braceland, Francis J., M.D. Psychiatry and atoms. Mental hygiene, 31:29–37, January 1947.

Brenman, Margaret, Gill, M. M., M.D. and Hacker, F. J., M.D. Alterations in the state of the ego in hypnosis. Bulletin of the Menninger clinic, 11: 60–66, March 1947.

Brenner, Ruth F. The selection of adoptive parents: a casework responsibility. Child welfare league of America, Bulletin, 25:1–6, December 1946.

Breyer, Frederick A. Juvenile delinquency. Hygeia, 25:178–79, 220, March 1947.

Brill, Norman Q., M.D. Army experience proves that psychiatric patients belong in a general hospital. Modern hospital, 68:56–57, January 1947.

British medical groups study psychiatric services. Child, U. S. Children's bureau, 11:121, January 1947.

Brodman, Keeve, M.D. and others. The incidence of personality disturbances and their relation to age, rank and duration of hospitalization in patients with medical and surgical disorders in a military hospital. Psychosomatic medicine, 9:45–49, January–February 1947.

Brodman, Keeve, M.D. and others. The relation of personality disturbances to duration of convalescence from acute respiratory infections. Psychosomatic medicine, 9:37–44, January–February 1947.

Bunta, Emil, M.D. The essentials of genius. Illinois medical journal, 91: 40–46, January 1947.

Burton, Mary L. General implications of cerebral palsy. Journal of social casework, 28:91–95, March 1947.

Buxbaum, Edith. Activity and aggression in children. American journal of orthopsychiatry, 17:161–66, January 1947.

Bychowski, Gustav, M.D. The rebirth of a woman: a psychoanalytic study of artistic expression and sublimation. Psychoanalytic review, 34: 32–57, January 1947.

Care of children. The Curtis report. Lancet (London), 251:648–49, November 2, 1946.

Carithers, Hugh A., M.D. and Carithers, C. M., M.D. Lost! an appetite. Every child refuses food at times. If well-handled, the appetite holiday is only temporary. Parents' magazine, 21:36, 153–57, December 1946.

Cason, Hulsey. The symptoms of the psychopath. Public health reports, U. S. Public health service, 61:1833–53, December 20, 1946.

Cason, Hulsey and Pescor, M. J. A comparative study of recidivists and non-recidivists among psychopathic

federal offenders. Journal of criminal law and criminology, 37:236–38, September–October 1946.

Charbonneau, Leon O. Men nurses in psychiatric nursing in Veterans administration hospitals. American journal of nursing, 47:82, February 1947.

Charen, Sol. The military social worker—aide to psychiatrist. Social forces, 25:173–77, December 1946.

Clapper, Olive E. Youth and the uncertain world. National parent-teacher, 41:4–6, December 1946.

Clark, Tom C. Prevention and control of juvenile delinquency. Federal probation, 10:4–8, October–December 1946.

Clarke, E. K., M.D. and Law, S. G., M.D. Personality components in employment problems. Occupational medicine, 2:116–25, August 1946.

Cleckley, Hervey, M.D. The psychopath: a problem for society. Federal probation, 10:22–25, October–December 1946.

Cockerill, Eleanor E. The use of the psychosomatic concept in social case work. Bulletin of the Johns Hopkins hospital, 80:86–97, January 1947.

Cohen, Louis H., M.D. and Coffin, T. E. The pattern of murder in insanity: a criterion of the murderer's abnormality. Journal of criminal law and criminology, 37:262–87, November–December 1946.

Cohen, Robert A., M.D. Military group psychotherapy. Mental hygiene, 31: 94–102, January 1947.

Conference on mental health: The lessons of war; Employment of the handicapped. Lancet (London), 251: 763–65, November 23, 1946.

Cooper, Evelyn F. Medical social problems of rheumatic heart disease in the adult. Journal of social casework, 28:51–56, February 1947.

Cossa, P., M.D. Letter from France. American journal of psychiatry, 103: 433–39, January 1947.

Cotton, Henry A., Jr., M.D. and Ebaugh, F. G., M.D. Japanese neuropsychiatry. American journal of psychiatry, 103:342–48, November 1946.

Crichton-Miller, H., M.D. The value of an illusion. Mental hygiene, 31: 38–49, January 1947.

Crime: causes and prevention. Federal probation, 10:36–40, October–December 1946.

Cruickshank, William M. Arithmetic vocabulary of mentally retarded boys. Journal of exceptional children, 13:65–69, 91, December 1946.

Cunningham, James M., M.D. Problems in the vocational rehabilitation of persons with psychiatric handicaps. Journal of rehabilitation, 12:18–22, December 1946.

Cunningham, James M., M.D. Second progress report—Bureau of mental hygiene. Connecticut health bulletin, State department of health, 60:283–85, December 1946.

Dalton, Robert H. Developing control for democratic living. Journal of home economics, 39:1–4, January 1947.

Davidoff, Eugene, M.D. Future proposals with respect to the function of personnel consultation services. Diseases of the nervous system, 8:16–23, January 1947.

Davidson, Henry A., M.D. Orientation to psychosomatics. Military surgeon, 100:47–50, January 1947.

Davis, Allison and Havighurst, R. J. Social class and color differences in child-rearing. American sociological review, 11:698–710, December 1946.

Davis, Kingsley. Final note on a case of extreme isolation. American journal of sociology, 52:432–37, March 1947.

Day, George, M.D. Observations on the psychology of the tuberculous. Lancet (London), 251:703–6, November 16, 1946.

Delehanty, Edward, Jr., M.D. State hospital care of alcoholics in Colorado. Diseases of the nervous system, 8:40–42, February 1947.

Dengrove, Edward, M.D. Psychosomatic aspects of dermographia and pruritus; report of two cases. Psychosomatic medicine, 9:58–61, January–February 1947.

De Schweinitz, Elizabeth and De Schweinitz, Karl. The place of authority in the protective function of the public welfare agency. Child welfare league of America, Bulletin, 25:1–6, September 1946.

Des Lauriers, Austin and Halpern, Florence. Psychological tests in childhood schizophrenia. American journal of orthopsychiatry, 17:57–67, January 1947.

Deutsch, Felix, M.D. The use of the psychosomatic concept in medicine. Bulletin of the Johns Hopkins hospital, 80:71–85, January 1947.

Draper, Paul A., M.D. Prefrontal lobotomy in the treatment of schizophrenia. Diseases of the nervous system, 8:77–80, March 1947.

Dunton, William R., Jr., M.D. Recreation and music therapy. Occupa-

tional therapy and rehabilitation, 25:247–52, December 1946.

Du Shane, Donald. The schools and juvenile delinquency. NEA journal, National education association, 36: 100–1, February 1947.

Dynes, John B., M.D. Objective method for distinguishing sleep from the hypnotic trance. Archives of neurology and psychiatry, 57:84–93, January 1947.

Ebaugh, Franklin G., M.D. Present-day concepts of the psychoneuroses. Pennsylvania medical journal, 50: 361–69, January 1947.

Ebaugh, Franklin G., M.D. and Hoekstra, C. S., M.D. Psychosomatic relationships in acute anterior poliomyelitis. American journal of the medical sciences, 213:115–21, January 1947.

Eccles, August K. An inquiry into the verbal facility of delinquent boys. Training school bulletin, 43:157–60, December 1946.

Elkes, Regina. Group-casework experiment with mothers of children with cerebral palsy. Journal of social casework, 28:95–101, March 1947.

Elkisch, Paula. The emotional significance of children's art work. Childhood education, 23:236–41, January 1947.

Evans, Harrison. As a man thinketh so is he. Life and health, 62: 12–13, March 1947.

Eysenck, H. J. The measurement of personality. [Résumé] Proceedings of the Royal society of medicine, Section of psychiatry (London), 40: 75–80, December 1946.

Fabian, A. A., M.D. and Bender, Lauretta, M.D. Head injury in children: predisposing factors. American journal of orthopsychiatry, 17:68–79, January 1947.

Faris, Ellsworth. Some results of frustration. Sociology and social research, 31:87–92, November–December 1946.

Feldman, Fred, M.D. and others. Ambulatory electroconvulsive therapy. Journal of nervous and mental disease, 105:171–90, February 1947.

Felix, Robert H., M.D. The relation of the National mental health act to state health authorities. Public health reports, U. S. Public health service, 62:41–49, January 10, 1947.

Fetterman, Joseph L., M.D. Advances in electro-coma therapy of psychoses. Ohio state medical journal, 42: 1133–36, November 1946.

Fetterman, Joseph L., M.D. and others. Ambulatory electro-coma therapy of psychoses. Diseases of the nervous system, 8:5–10, January 1947.

Fischer, Alfred E., M.D. and Dolger, Henry, M.D. Behavior and psychologic problems of young diabetic patients: a ten to twenty year survey. Archives of internal medicine, 78:711–32, December 1946.

Fishbein, Elsie P. New ideas in child development; a review of recent authoritative books on child guidance. Hygeia, 25:201, 224, 226, March 1947.

Fisher, Dorothy C. Learning to give and to share. Parents' magazine, 21:18–19, 90–93, December 1946.

Fleming, Joan, M.D. Observations on the defenses against a transference neurosis. Psychiatry, 9:365–74, November 1946.

Fleming, Louise and Snyder, W. U. Social and personal changes following nondirective group play therapy. American journal of orthopsychiatry, 17:101–16, January 1947.

Floch, Maurice. Group therapy in a women's prison. Federal probation, 10:34–36, October–December 1946.

Font, Marion M. What happens to children who cannot read? Journal of exceptional children, 13:70–72, 96, December 1946.

Foster, Constance J. How children grow. Parents' magazine, 22:18–19, 134–37, March 1947.

Frank, Alan. Review of some fundamental considerations in psychotherapy. Diseases of the nervous system, 8:69–73, March 1947.

Freeman, Henry. Casework with families of mental hospital patients. Journal of social casework, 28:107–13, March 1947.

Friedman, Jacob H., M.D. and others. The psychosomatic factors in pulmonary tuberculosis: a study of one hundred consecutive army cases. Diseases of the chest, 12:539–49, November–December 1946.

Fries, Margaret E., M.D. Diagnosing the child's adjustment through age-level tests. Psychoanalytic review, 34:1–31, January 1947.

Fromm-Reichmann, Frieda, M.D. Remarks on the philosophy of mental disorders. Psychiatry, 9:293–308, November 1946.

Fry, Clements C., M.D. Art in the history of medicine. The sixteenth century cures for lunacy. American journal of psychiatry, 103:351–52, November 1946.

Futterman, Samuel, M.D. Ego strengths and therapy. News-letter, American

association of psychiatric social workers, 16:48–51, Autumn 1946.

Galdston, Iago, M.D. On the etiology of depersonalization. Journal of nervous and mental disease, 105: 25–39, January 1947.

Gamble, Clarence J., M.D. Preventive mental hygiene in Iowa. Journal of the Iowa state medical society, 37: 68–71, February 1947.

Garry, Mark W., M.D. Tuberculosis in mental schools and hospitals in Ohio. Ohio state medical journal, 42:1265–70, December 1946.

Gauss, Harry, M.D. Mucous colitis. The disease is, in reality, a neurosis of the colon—a psychic phenomenon in which the sick person's digestive tract tries to express his repressed emotions. Hygeia, 25:120–21, 159, February 1947.

Geoghegan, John J., M.D. The "shock therapies" at the Ontario hospital, London. Canadian medical association journal (Montreal), 56:15–24, January 1947.

Gesell, Arnold, M.D. Developmental pediatrics. Journal of pediatrics, 30: 188–94, February 1947.

Gideonse, Harry D. The golden opportunity for public education. Mental hygiene, 31:14–28, January 1947.

Gilbert, Louise. Foster home care in rural areas. Journal of social casework, 28:67–72, February 1947.

Gilliland, Esther G. Are you making the most of music? Occupational therapy and rehabilitation, 25:238–40, December 1946.

Ginsburg, Ethel L. The psychiatric social worker in a veterans service center. News-letter, American association of psychiatric social workers, 16:33–39, Autumn 1946.

Greenacre, Phyllis, M.D. Child wife as ideal: sociological consideration. American journal of orthopsychiatry, 17:167–71, January 1947.

Greenhill, Maurice H., M.D. Clinical features of the psychoneuroses in World war II veterans. North Carolina medical journal, 7:585–90, November 1946.

Gregory, W. Edgar. The chaplain and mental hygiene. American journal of sociology, 52:420–23, March 1947.

Hadden, Samuel B., M.D. Post-military group psychotherapy with psychoneurotics. Mental hygiene, 31:89–93, January 1947.

Halsted, James A., M.D. The management of "soldier's stomach" among combat infantrymen: evaluation of psychiatric and physical factors. Journal of nervous and mental disease, 105:116–23, February 1947.

Handley, Katharine N. Social casework and intercultural problems. Journal of social casework, 28:43–50, February 1947.

Harrington, D. O., M.D. Ocular manifestations of psychosomatic disorders. Journal of the American medical association, 133:669–75, March 8, 1947.

Hartwell, Samuel W., M.D. The teacher and mental health. Michigan public health, State department of health, 35:11–14, January 1947.

Hawley, Paul R., M.D. Neuropsychiatric problems of the Veterans administration. Military surgeon, 99: 759–62, December 1946.

Haynes, Elmer, M.D. and Dallis, N. P., M.D. Epilepsy. Ohio state medical journal, 43:145–47, February 1947.

Health, S. R., Jr. The teaching of reading in a military setting. Training school bulletin, 43:150–56, December 1946.

Hebb, D. O. Spontaneous neurosis in chimpanzees. Psychosomatic medicine, 9:3–19, January–February 1947.

Heller, Phyllis B. Do you spoil your children? Parents' magazine, 22: 22–23, 93, January 1947.

Hewlett, Irma W. News about asthma. We're learning more and more about the part emotions play in illness. It's particularly true of asthma. Parents' magazine, 22:36, 86–89, February 1947.

Hinkle, Lawrence E., Jr. Neuropsychiatric problems on a battleship. U. S. naval medical bulletin, 46:1813–22, December 1946.

Hirshberg, Bernard. Me too. Hygeia, 25:28, January 1947.

Houk, Theodore W., M.D. and Robertson, Yvonne. Diagnosis of hypoglycemia-neurosis with Minnesota multiphasic personality inventory. Northwest medicine, 45:923, December 1946.

Houtz, Fanny and Kostick, Evelyn. Preparation of juvenile delinquents for treatment. American journal of orthopsychiatry, 17:143–50, January 1947.

Howard, Lois G. What to do about fears. Parents' magazine, 22:22–23, 175–77, March 1947.

Hummon, Irvin F., Jr., M.D. Outlook for the cerebral palsied child. Crippled child. 24:7–9, December 1946.

Hurlin, Ralph G. Salaries in mental hygiene clinics in 1946. News-letter, American association of psychiatric

social workers, 16:51–52, Autumn 1946.

Hutchinson, Dorothy C. H. Reëxamination of some aspects of case work practice in adoption. Child welfare league of America, Bulletin, 25:4–7, 14, November 1946.

Hutt, Max L., Menninger, W. C., M.D. and O'Keefe, D. E. The neuropsychiatric team in the United States army. Mental hygiene, 31:103–19, January 1947.

Hymes, James L., Jr. The teacher can prevent. Child study, 24:41–42, 63, Winter 1946–47.

Johnson, Richard H. Helping the youthful offender. Federal probation, 10:32–34, October–December 1946.

Kallmann, Franz J., M.D. The genetic theory of schizophrenia: an analysis of 691 schizophrenic twin index families. American journal of psychiatry, 103:309–22, November 1946.

Kallmann, Franz J., M.D. and Anastasio, M. M. Twin studies on the psychopathology of suicide. Journal of nervous and mental disease, 105: 40–55, January 1947.

Karpman, Benjamin, M.D. Felonious assault revealed as a symptom of abnormal sexuality: a contribution to the psychogenesis of psychopathic behavior. Journal of criminal law and criminology, 37:193–215, September–October 1946.

Karpman, Benjamin, M.D. Passive parasitic psychopathy: toward the personality structure and psychogenesis of idiopathic psychopathy (anethopathy). Psychoanalytic review, 34:102–18, January 1947. (To be continued.)

Karpman, Benjamin, M.D. A yardstick for measuring psychopathy. Federal probation, 10:26–31, October–December 1946.

Kerman, Edward F. Proposal for creation of small, urbanly located state hospitals. Diseases of the nervous system, 8:85–94, March 1947.

Kerr, Marion J. The importance of preparing children for psychiatric treatment. Smith college studies in social work, 17:69–104, December 1946.

Kimball, Frank W. Hope for tired minds. Hygeia, 25:36–37, 64, 66, 68, January 1947. (Concluded.)

Kinder, Elaine F. and Clardy, E. R., M.D. Dealing with the child's emotional disturbances. National parent-teacher, 41:20–22, December 1946.

Klauminzer, Frederick A. and Kille, E. C. A training program for middle grade children at the Southbury training school. Occupational therapy and rehabilitation, 25:227–32, December 1946.

Knapp, Joseph L., M.D. Psychotherapy in the treatment of tuberculous patients. West Virginia medical journal, 43:12–15, January 1947.

Knight, Robert P., M.D. Psychotherapy of an adolescent catatonic schizophrenia with mutism: a study in empathy and establishing contact. Psychiatry, 9:323–39, November 1946.

Knop, Catharine, M.D. The dynamics of newly born babies. Journal of pediatrics, 29:721–28, December 1946.

Kupper, William H., M.D. Observations on the use of a phonograph record of battle sounds employed in conjunction with pentothal in the treatment of 14 cases of severe conversion hysteria caused by combat. Journal of nervous and mental disease, 105:56–60, January 1947.

LaBarre, Weston. Some observations on character structure in the Orient. II. The Chinese. Part 2. Psychiatry, 9:375–95, November 1946.

Laden, Alice. The use of the budget for earned income in helping the adolescent in placement. Child welfare league of America, Bulletin, 25: 6–7, 9–12, September 1946.

LaMaster, Robert J. Music therapy as a tool for treatment of mental patients in the hospital. Hospital management, 62:110, 112, 114, December 1946. (To be concluded.)

Lambert, Clara. Play is their job. Play is a powerful developmental force which needs help and direction. Parents' magazine, 21:30–31, 135–40, December 1946.

The Lasker award in mental hygiene, presentation of. Mental hygiene, 31: 120–22, January 1947.

Laycock, Samuel R. Coöperating with parents of handicapped children. Journal of exceptional children, 13: 102–4, 128, January 1947.

Laycock, Samuel R. The mental hygiene view of character-education in schools. Understanding the child, 16:15–20, January 1947.

Leavitt, Harry C., M.D. A comparison between the neuropsychiatric screening adjunct (NSA) and the Cornell selectee index (form N). American journal of psychiatry, 103:353–57, November 1946.

Leavitt, Harry C., M.D. Neuropsychiatric appraisal in an induction station. Bulletin, U. S. Army medical department, 7:125–43, January 1947.

Lehmann, H., M.D. Psychoses with somatic disease. Canadian medical association journal, 55:557–59, December 1946.

Leion, Rose. First day in kindergarten or mother! Hygeia, 25:32–33, 52, 54–55, January 1947.

Lennox, William G., M.D. The genetics of epilepsy. American journal of psychiatry, 103:457–62, January 1947.

LeVay, A. David, M.B. Psychosomatic approach to orthopædic surgery. Lancet (London), 252:125–29, January 25, 1947.

Lewin, Bertram D., M.D. Sleep, the mouth, and the dream screen. Psychoanalytic quarterly, 15:419–34, October 1946.

Lewis, Nolan D. C., M.D. What should be taught. American journal of psychiatry, 103:450–56, January 1947.

Linck, Lawrence J. Toward a more adequate program of education for crippled children. Journal of exceptional children, 13:129–32, 160, February 1947.

Lindsay, Inabel B. Race as a factor in the caseworker's rôle. Journal of social casework, 28:101–7, March 1947.

Lipton, Harry R., M.D. The borderline and mentally defective prison inmate. Military surgeon, 100:62–64, January 1947.

Louttit, C. M. The school as a mental-hygiene factor. Mental hygiene, 31: 50–65, January 1947.

Lowrey, Lawson G., M.D. How about punishment? Parents' magazine, 22: 30–31, 101–2, 104–7, February 1947.

Ludwig, Alfred O., M.D., and Ranson, S. W., M.D. A statistical follow-up of effectiveness of treatment of combat-induced psychiatric casualties. I. Returns to full combat duty. Military surgeon, 100:51–62, January 1947.

Luhan, Joseph A., M.D. Reflections on the state of psychiatry in the realm of medicine. Diseases of the nervous system, 8:81–84, March 1947.

Lunden, Walter A. Suicides in France, 1910–43. American journal of sociology, 52:321–34, January 1947.

McClenahan, Bessie A. Interrelated patterns of community and personality: a hypothesis. Sociology and social research, 31:205–12, January–February 1947.

MacCurdy, Frederick, M.D. Evaluating administrative procedures in to-day's mental hospitals: Cinderella of medical and hospital family should sell public officials on requirements. Hospital management, 62:30–31, December 1946; 63:40–42, January 1947.

Manson, Morse P. and Grayson, H. M. The "sick book rider" in an overseas military prison. Psychosomatic medicine, 8:414–16, November–December 1946.

Markey, Oscar B., M.D. and Zisson, M. M. A psychiatric screening aid for pre-combat troops. American journal of psychiatry, 103:377–80, November 1946.

Martens, Elise H. Life adjustment for the seriously disabled. Journal of exceptional children, 13:109–13, 128, January 1947.

Meadows, Clarence W. Prevention, not cure, is the most hopeful approach to the delinquency problem. Federal probation, 10:8–10, October–December 1946.

The meaning of psychosomatic medicine. Editorial. New England journal of medicine, 236:83–84, January 9, 1947.

Meduna, Ladislas J., M.D. Pharmacodynamic treatment of psychoneuroses. (A preliminary report.) Diseases of the nervous system, 8:37–40, February 1947.

Meld, Murray B. The meaning of vocational guidance for the veteran. Journal of social casework, 28:17–21, January 1947.

Menninger, Karl A., M.D. Psychiatry and psychology. Bulletin of the Menninger clinic, 11:45–49, March 1947.

Menninger, Karl A., M.D., Rapaport, David and Schafer, Roy. The new rôle of psychological testing in psychiatry. American journal of psychiatry, 103:473–76, January 1947.

Merritt, Hiram H., M.D. Recent advances in the treatment of epilepsy. New York state journal of medicine, 46:2629–33, December 1, 1946.

Meyer, Charlene T. The assertive behavior of children as related to parent behavior. Journal of home economics, 39:77–80, February 1947.

Michaels, Joseph J., M.D. Note on "evacuation and the isolated child." American journal of orthopsychiatry, 17:176–78, January 1947.

Moloney, James C., M.D. The analyst remains silent. Diseases of the nervous system, 8:14–16, January 1947.

Montgomery, Bernard L., 1st viscount. Morale in battle. Address given to the Royal society of medicine. British medical journal (London), p. 702–4, November 9, 1946.

Moody, Robert L., M.B. Bodily changes during abreaction. Lancet (London), 251:934–35, December 28, 1946.

Moriarty, John D., M.D. A survey of 5,000 psychotic patients (evacuated to a U. S. naval hospital from the Pacific: and a rehabilitation program). Diseases of the nervous system, 8:27–29, January 1947.

Morlock, Maud. Adoption. Child welfare league of America, Bulletin, 25: 7, 12–13, December 1946.

Morlock, Maud. Relinquishment and adoption. Child welfare league of America, Bulletin, 25:1–4, November 1946. (To be continued.)

Morris, Charles M. Pity the normal child. Hygeia, 25:40–41, 48, January 1947.

Moses, Leon, M.D. Psychodynamic and electroencephalographic factors in duodenal ulcer. Psychosomatic medicine, 8:405–9, November–December 1946.

Murphy, Lois B. Who are the children who need psychiatric guidance? Journal of home economics, 39:27–29, January 1947.

Myerson, Abraham, M.D. Family mental disease in private practice. American journal of psychiatry, 103:323–37, November 1946.

Naranick, Claudia S. The overactive patient. American journal of nursing, 47:97–102, February 1947.

Neal, Helen S. Must children compete? Some competition is inevitable, but children need protection from unnecessary rivalry and encouragement to develop their individual capabilities. Parents' magazine, 22:26, 122–23, February 1947.

Neuber, Margaret A. and Snyder, W. U. Evaluating a special class in terms of personality development. Journal of exceptional children, 13: 135–40, February 1947.

Newell, Nancy L. Mental health and ill health among youth. Understanding the child, 16:3–6, January 1947.

Novick, Rudolph G., M.D. New trends in the care of the mentally ill. Mental health bulletin, Illinois society for mental hygiene, 24:1–2, 4, November–December 1946.

Oberndorf, Clarence P., M.D. Constant elements in psychotherapy. Psychoanalytic quarterly, 15:435–49, October 1946.

O'Connor, H. T. To help prevent delinquent trends. Journal of home economics, 38:557–61, November 1946.

Olds, F. P. The juvenile court as a diagnostic and treatment agency. Probation, National probation association, 25:51–57, December 1946.

Overstreet, Bonaro W. How to think about yourself. IV. You are the maker of a culture. National parent-teacher, 41:7–9, December 1946.

Perlstein, Meyer A., M.D. and Shere, Marie. Speech therapy for children with cerebral palsy. American journal of diseases of children, 72:389–98, October 1946.

Peterman, Mynie G., M.D. Convulsions in childhood: twenty year study of 2,500 cases. American journal of diseases of children, 72:399–410, October 1946.

Pfeffer, Arnold Z., M.D. and Ruble, D. C. Chronic psychoses and addiction to morphine. Archives of neurology and psychiatry, 56:665–72, December 1946.

Plant, James S., M.D. The public health nurse as a medium for mental health. Public health nursing, 39: 3–6, 12, January 1947.

Polatin, Phillip, M.D. and Spotnitz, Hyman, M.D. Effects of combined ambulatory insulin and electroshock therapy in the treatment of schizophrenia. (A preliminary report.) New York state journal of medicine, 46:2648–50, December 1, 1946.

Porter, William C., M.D. and Davidson, H. A., M.D. Alumni appraisal of psychiatric education. American journal of psychiatry, 103:440–45, January 1947.

Powdermaker, Florence, M.D. The neuropsychiatric training program of the Veterans administration. American journal of psychiatry, 103:470–72, January 1947.

Proctor, Eleanor. A community initiates services to unmarried mothers. Child welfare league of America, Bulletin, 25:9–11, December 1946.

Rathbun, Constance. Psycho-physical reactions to placement. Journal of social casework, 28:61–67, February 1947.

Reese, Hans H., M.D. Progress in neurology and psychiatry. Illinois medical journal, 91:16–24, January 1947.

Reichard, J. D., M.D. Some myths about marihuana. Federal probation, 10:15–22, October–December 1946.

Rennie, Thomas A. C., M.D., Swackhamer, Gladys and Woodward, L. E. Towards industrial mental health; an historical review. Mental hygiene, 31:66–88, January 1947.

Review of psychiatric progress 1946. American journal of psychiatry, 103:513–59, January 1947.

Contents: Heredity and eugenics, by F. J. Kallmann, M.D.—Neuropathology, biochemistry and endocrinology, by Orthello Langworthy, M.D. and J. C. Whitehorn, M.D.—Electroencephalography, by F. A. Gibbs, M.D.—Epilepsy, by W. G. Lennox, M.D. and J. P. Davis, M.D.—Neurosyphilis, by A. S. Rose, M.D. and H. C. Solomon, M.D.—Alcohol. Geriatrics, by K. M. Bowman, M.D.—Child psychiatry. Mental deficiency, by Leo Kanner, M.D.—Psychometrics, by F. L. Wells.—General clinical psychiatry, psychosomatic medicine and psychosurgery, by N. D. C. Lewis, M.D.—Physiological treatment of psychoses, by Joseph Wortis, M.D.—Family care and out-patient mental clinics in 1946, by H. M. Pollock.—Psychiatric nursing, by M. E. Corcoran. — Psychiatric social work, by T. A. C. Rennie, M.D.—Occupational therapy, by L. F. Woolley, M.D.—Psychiatry in industry, by C. C. Burlingame, M.D.—Administrative, forensic and military psychiatry, by Winfred Overholser, M.D.—Psychiatric education, by C. A. Rymer, M.D.

Richards, Esther L., M.D. The mental health of childhood requires active, continuous coöperation between pediatrician and psychiatrist. Modern hospital, 68:63–64, February 1947.

Riggs, Frieda W. In the service of children. Journal of social casework, 28:21–26, January 1947.

Ripley, Herbert S., M.D. and Wolf, Stewart, M.D. Mental illness among Negro troops overseas. American journal of psychiatry, 103:499–512, January 1947.

Robinson, Reginald. Beneath the surface of juvenile delinquency and child neglect. Survey midmonthly, 83:41–52, February 1947.

Rockmore, Myron J. A psychiatric social casework orientation to therapy. News-letter, American association of psychiatric social workers, 16:39–46, Autumn 1946.

Rockwell, Fred V., M.D. and Simons, D. J., M.D. The electroencephalogram and personality organization in the obsessive-compulsive reactions. Archives of neurology and psychiatry, 57:71–77, January 1947.

Róheim, Géza. The Œdipus complex and infantile sexuality. Psychoanalytic quarterly, 15:503–8, October 1946.

Rosenzweig, Saul and Isham, A. C. Complementary Thematic apperception test patterns in close kin. American journal of orthopsychiatry, 17:129–42, January 1947.

Roth, Nathan, M.D. The relationship of neurology and psychiatry. Diseases of the nervous system, 8:47–49, February 1947.

Russell, David H. Reading disabilities and mental health: a review of research. Understanding the child, 16: 24–32, January 1947.

Russell, William L., M.D. The National mental health act. American journal of psychiatry, 103:417–20, November 1946.

Schaffner, Bertram. Analysis of a spontaneous story in postwar Germany. American journal of orthopsychiatry, 17:172–75, January 1947.

Scherz, Frances H. "Taking sides" in the unmarried mother's conflict. Journal of social casework, 28:57–61, February 1947.

Schmideberg, Melitta, M.D. Can criminals be analyzed? Journal of social casework, 28:83–90, March 1947.

Schmideberg, Melitta, M.D. On querulance. Psychoanalytic quarterly, 15: 472–502, October 1946.

Schmideberg, Melitta, M.D. The psychological treatment of adult criminals. Probation, National probation association, 25:45–50, December, 1946.

Schmidl, Fritz. The Rorschach test in juvenile delinquency research. American journal of orthopsychiatry, 17: 151–60, January 1947.

Schneck, Jerome M., M.D. The psychological component in a case of herpes simplex. Psychosomatic medicine, 9:62–64, January–February 1947.

Schryver, Selina, M.D. Technique of psychotherapy for children. Archives of pediatrics, 63:622–29, December 1946.

Schumacher, Henry C., M.D. Schizophrenia in children. Ohio state medical journal, 42:1248–54, December 1946.

Seeman, Melvin. An evaluation of current approaches to personality differences in folk and urban societies. Social forces, 25:160–65, December 1946.

Sherwin, May R. S. A. means socially acceptable. All parents want their children to be popular and to get along well with people. There are ways to help them. Parents' magazine, 21:22–23, 94–97, December 1946.

Shorvon, Hyam J., M.B. The depersonalization syndrome. Proceedings of the Royal society of medicine (London), 39:779–92, October 1946.

Shryock, Harold, M.D. Why nervousness at forty-five? Hygeia, 25:206, 208, 210, 212, March 1947.

Sillman, Leonard R., M.D. The dynamics of schizophrenia. Journal of nervous and mental disease, 105: 61–72, January 1947.

Simon, Benjamin, M.D. and others. Cerebral dysrhythmia and psychopathic personalities: a study of ninety-six consecutive cases in a military hospital. Archives of neurology and psychiatry, 56:677–85, December 1946.

Simon, Benjamin, M.D. and others. Group therapy from the viewpoint of the patient. Journal of nervous and mental disease, 105:156–70, February 1947.

Simon, Clarence T. Speech training for cerebral palsied children. Crippled child, 24:20–21, 30–31, December 1946.

Special section on psychiatric service. [McMillan hospital, St. Louis]. Hospitals, 21:45–61, January 1947.

Three-year report, by F. R. Bradley, M.D.—The neurosurgeon says, by H. G. Schwartz, M.D.—A trend in medicine, by S. R. Warson, M.D.—Admitting technique, by Mrs. C. S. Knowles and Frank Wissmath, M.D. —Nursing procedures, by Stella Amass.—Occupational therapy, by M. E. Bick.—Social case work, by A. D. Buchmueller. — Neuropsychiatric clinic, by G. F. Stephens.

Stanfield, Clyde E., M.D. Personality repercussions of anterior poliomyelitis: a review of the literature. American journal of the medical sciences, 213:109–14, January 1947.

Stanka, Hugo, M.D. Congenital abnormalities of mental patients. Illinois medical journal, 91:46–48, January 1947.

Stearns, Albert W., M.D. A history of the development of the concept of functional nervous disease during the past twenty-five hundred years. American journal of psychiatry, 103: 289–308, November 1946.

Stern, Karl, M.D. and Prados, Miguel, M.D. Personality studies in menopausal women. American journal of psychiatry, 103:358–68, November 1946.

Stevens, Rutherford B., M.D. Racial aspects of emotional problems of Negro soldiers. American journal of psychiatry, 103:493–98, January 1947.

Stone, L. Joseph. The earliest years. Child study, 24:38–40, 55, Winter 1946–47.

Strecker, Edward A., M.D. The seeds of immaturity. Pennsylvania medical journal, 50:377–83, January 1947.

Tallman, Frank F., M.D. Food and the mentally ill. Journal of the American dietetic association, 23: 6–7, January 1947.

Tallman, Frank F., M.D. A mental hygiene program for Ohio: a blue print for action. Ohio state medical journal, 43:37–41, January 1947.

Tappan, Paul W. The adolescent in court. Journal of criminal law and criminology, 37:216–29, September–October 1946.

The teacher in the community. Howard A. Lane, Issue editor. Journal of educational sociology, 20:257–313, January 1947.

Contents: Community neglect of children, by A. V. Keliher.—The community and child development, by D. W. Dodson.—An education-centered community can care for children, by H. A. Lane.—The neighborhood is our classroom, by Letty Telford and Jane Stewart.—Training teachers for modern education: the pre-service program of New York university, by C. S. Platt.—Significant developments in education: St. Louis and its educational leadership, by E. G. Payne.

Tilly, Margaret. The psychoanalytical approach to the masculine and feminine principles in music. American journal of psychiatry, 103:477–83, January 1947.

Timmons, B. F. and Caraway, Iris. The rôle of the library in family life education. Marriage and family living, 9:13–15, 21, February 1947.

Tompkins, Harvey J., M.D. and Snedeker, A. W., M.D. Care and treatment of the psychiatric patient in the Veterans administration. American journal of psychiatry, 103:467–69, January 1947.

Trainham, Genevieve and Montgomery, J. C., M.D. Developmental factors in learning bowel and bladder control. American journal of nursing, 46:841–44, December 1946.

The unstable adolescent girl. British medical journal (London), p. 909–12, December 14, 1946.

Waggoner, Raymond W., M.D. and Zeigler, T. W. Psychiatric factors in medical students who fail. American journal of psychiatry, 103:369–76, November 1946.

Wagner, Philip S., M.D. Psychiatric activities during the Normandy offensive, June 20–August 20, 1944: an experience with 5,203 neuropsychiatric casualties. Psychiatry, 9:341–64, November 1946.

Walker, Charlotte F., M.D. and Kirkpatrick, B. B. Dilantin treatment for behavior problem children with abnormal electroencephalograms. American journal of psychiatry, 103: 484–92, January 1947.

Watts, Cuthbert, A. H., M.B. Endogenous depression in general practice. British medical journal (London), p. 11–14, January 4, 1947.

Weider, Arthur and others. The Cornell index: a method for quickly assaying personality and psychosomatic disturbances, to be used as an adjunct to interview. Psychosomatic medicine, 8:411–13, November–December 1946.

Weinberg, Maximilian H., M.D. The eclectic approach in the treatment of the neuroses. Pennsylvania medical journal, 50:370–76, January 1947.

Wendell, Jessie R. Recovery, for what? Modern hospital, 67:67–69, December 1946. (Continued from November issue.)

West, Ranyard, M.D. Psychotherapy of ulcerative colitis. Lancet (London), 251:899–903, December 21, 1946.

What is ahead in orthopsychiatry? Round table, 1946. Luther E. Woodward, Chairman. American journal of orthopsychiatry, 17:1–39, January 1947.

Whipple, Dorothy V., M.D. Self-demand babies. Parents' magazine, 21:20–21, 124–25, December 1946.

Whitehorn, John C., M.D. Psychiatry in medical education: the teacher-characteristics and qualifications. American journal of psychiatry, 103:446–49, January 1947.

Whitman, Samuel. Things to remember. Parents' magazine, 22:17, 142–43, March 1947.

Witty, Paul. Reading problems in the secondary school. School and society, 65:113–16, February 15, 1947.

Wofinden, Robert C., M.D. Problem families. Eugenics review, 38:127–32, October 1946.

Wolf, Anna W. M. Problem parents. Child study,. 24:35–37, 64, Winter 1946–47.

Wolkomir, Belle. They are adoptable. JCCA [Jewish child care association] finds good homes and adoptive parents for children whose heredity is 'dangerous.' Better times, Welfare council of New York City, 28:1–2, 10, January 31, 1947.

Wolkomir, Belle. The unadoptable baby achieves adoption. Child welfare league of America, Bulletin, 26: 1–7, February 1947.

Wulff, M., M.D. Fetishism and object choice in early childhood. Psychoanalytic quarterly, 15:450–71, October 1946.

Yorke, Gertrude C. Road to reëducation. Types of abnormal drinkers and treatment "must's." Survey midmonthly, 82:287–88, November 1946.

Young, David A., M.D. Interest in psychiatry as a part of medical practice. North Carolina medical journal, 7: 648–50, December 1946.

Young, Leontine R. The unmarried mother's decision about her baby. Journal of social casework, 28:27–34, January 1947.

Zehrer, Frederick A. The veteran returns to high school. Understanding the child, 16:7–10, January 1947.

Zeitlin, Jerome. Adoption agencies can help. A note on public relations in the fight against the "black market in babies." Channels, National publicity council, 24:1–4, 18–20, December 1946.

Zeller, Charles A., M.D. Mental health in Michigan. Michigan public health, State department of health, 34:206, 219, November 1946.